



October 30, 2019

Ms. Krista Lee Carsner, Executive Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

RE: Automated Health Services – Amendment #3
Altruista Health, Inc. – Amendment #2
Blue Cross Blue Shield of Tennessee, Inc. (CoverKids) – Amendment #6
Clear2There – Amendment #2
Edifecs, Inc. – Amendment #1
Health Management System, Inc. – Amendment #2
(MCO): Amerigroup Tennessee, Inc. – Amendment #11
(MCO): UnitedHealthcare Community Plan, Inc. – Amendment #11
(MCO): VSHP BlueCare Tennessee – Amendment #11
(MCO): Volunteer State Health Plan, Inc. – Amendment #46
Myers & Stauffer, LC – Amendment #2
Navigant Consulting, Inc. – Amendment #3
Proteus, Inc. (New Contract)

Dear Ms. Lee Carsner:

The Department of Finance and Administration, Division of TennCare, is submitting for consideration by the Fiscal Review Committee the required documentation for twelve (12) Amendments and one (1) new Contract as follows:

- 1) Automated Health Services:** Automated Health Systems, Inc. (AHS) is the competitively procured contractor for the provision of a TennCare/Chip Member Service Center. TennCare seeks to exercise an additional 16-month term which is beyond the requisite 60-months for TennCare/CHIP Member Services. With the recent implementation of the Tennessee Eligibility Determination System (TEDS), the State has experienced a significant increase in call volume and call time handling and continued business process enhancements due to the integration of the new eligibility system.

These elements continue to change as the State fully operationalizes the full functionality of TEDS. Lastly, while integrating the TEDS system into existing business operations, the State recognized the need to explore additional changes to TEDS which would greatly impact the future scope of work of the TennCare service centers document management solution, specifically optical recognition technology, for a new Request for Proposal and subsequent replacement contract. To meet the needs of the State from a planning perspective and sustain a satisfactory level of customer service to a vulnerable service population, TennCare respectfully requests approval of the proposed term extension.

- 2) Altruista Health, Inc.:** This competitively procured contract with Altruista Health Inc., was put into place for the provision of providing and implementing an Off the Shelf Solution (Solution)

with customizations that allows health care providers the ability to coordinate patients across multiple payers, plan types including Medicaid, Medicare, and Commercial plans. The primary use of this tool in the first phase was to enhance transitions of care and allow for potential future expansion to leverage this tool to enhance care coordination and management across the State's Medicaid enterprise. TennCare is seeking to exercise the second of two (2) renewal options as allowed in Section B.2. of contract 48925 as well as increase the maximum liability in order to continue regular payments to accommodate for the extended term.

- 3) **BlueCross Blue Shield of Tennessee, Inc. (CoverKids):** This contract provides delivery of CoverKids services to the eligible CoverKids population. This amendment is necessary to: (1) delete all sections that are no longer applicable and/or outdated contract language; (2) update the scope of service sections as they relate to program updates; (3) add funding, exercise a renewal option, and adjust appropriate language to the Performance Guarantee section which correlates to the scope replacements.
- 4) **Clear2There:** C2T is the only telephone bridging and digital recording system specifically created and designed for state appeals hearings. There is no other system that allows the state hearing schedule data to be uploaded to the vendors' database in order to provide meaningful indexing and search capabilities, as well as autodialing of the party phone numbers. C2T's system is specific to meeting the technical and legal requirements for appeals hearings. The appeal volume and necessity of hearing procedures provided by C2T has greatly impacted TennCare. The web-based functionality has all but eliminated the need of using court reporters as well as allowed TennCare to utilize digital storage, housing, and digital searching mechanisms that are not otherwise available or in use by standard court reporters. The purpose of this request is to exercise the second renewal option in accordance with Section B.1 of Contract 56441.
- 5) **Edifecs, Inc.:** Edifecs, Inc. is the competitively procured contractor for the provision of the statewide development, implementation, and maintenance of a service to collect clinical quality data that cannot be acquired from processed medical billing claims. Ultimately, these Quality Applications provide all payers, including TennCare, commercial insurers, and Medicare Advantage plans with the necessary information to reimburse providers for high quality health outcomes. Quality Applications are based on a contractor-provided service that support two innovation strategies: Episodes of Care and Long-Term Services and Supports (LTSS). As part of payment reform efforts within the Tennessee Health Care Innovation Initiative, these two strategies increase quality of care, reduce health care costs, and improve Tennessee's population health. Episodes of Care Quality Applications track certain quality measures for clinical encounters that are not included in medical billing claims data. LTSS Quality Applications support the payment calculations, data aggregation, and quality measures for Nursing Facilities and Home and Community Based Services (HCBS) programs. TennCare seeks to exercise the first of two renewal options as provided in Section B.2. of Contract 53564.
- 6) **Health Management System, Inc.:** This competitively procured contract with Health Management Systems, Inc. is for the provision of Third Party Liability recovery services. It is necessary to amend the contract to add funding to support the continuation of recovery and cost avoidance services throughout the remainder of the term and to also exercise a renewal option as laid out in contract section B.2. The recoveries associated with this contract are not amounts that can easily be projected and vary significantly from one payment cycle to the other,

depending on the dollar amounts of recoveries made, as well as the percentage of reimbursement to the contractor according to their cost and associated rates and percentage of reimbursement in the contract.

Managed Care Organization (MCO) 7, 8, 9 are combined:

- 7) Amerigroup Tennessee, Inc. (Edison # 40180, Amendment #11)**
- 8) UnitedHealthcare Plan of the River Valley, d/b/a UnitedHealthcare Community Plan (Edison # 40181, Amendment #11)**
- 9) Volunteer State Health Plan, Inc. d/b/a Blue Care Tennessee (Edison # 40197, Amendment #11):**

These competitively procured contracts are being amended to provide relative changes to the managed care program including:

- CoverKids Implementation Requirements for January 1, 2021 Effective Date
- Updated language to address CMS's Focused Program Integrity Review of Personal Care Services and PI Investigator credentials
- EVV Compliance changes to include changes to LDs
- Clarifications around the new PCSP and Medication Risk Assessment Processes
- Correcting weighting errors from prior cycles
- Changes to required reporting for CHOICES and ECF CHOICES Advisory Groups
- Additions of Beneficiary Support System training and education
- Care Coordination and Support Coordination Changes as well as changes to Monitoring requirements
- Requirements for Contractors to collaborate with DIDD
- ECF CHOICES Quality Monitoring Changes
- WFD updates
- Direct Service Worker Oversight and Monitoring
- Requirements surrounding NCI and NCI-AD
- Updates to member handbook requirements
- Updates to Groups 7 & 8 reporting requirements
- Update Population Health language to reflect current program
- Clarifications to Turning 21 Transition requirements
- Medication Assisted Treatment language updated to include Methadone requirements
- Updated training requirements for PCMH, THL and EOC4
- Housekeeping updates to Reporting and Reporting Template requirements

- 10) Volunteer State Health Plan, Inc. – Amendment #46:** This contract is being amended to provide relative changes to the program including:

- Updated language to address CMS's Focused Program Integrity Review of Personal Care Services and PI Investigator credentials
- Update Population Health language to reflect current program
- Clarifications to Turning 21 Transition requirements
- Medication Assisted Treatment language updated to include Methadone requirements

- Updated training requirements for PCMH, THL and EOC4
- Housekeeping updates to Reporting and Reporting Template requirements

11) Myers & Stauffer, LC – Amendment #2: This competitively procured contractor, Myers and Stauffer, LC (MSLC), established benchmark reimbursement for covered outpatient drugs using an Average Actual Acquisition Cost (AAAC) cost methodology for pharmacies to be compliant with federal requirements of the Covered Outpatient Drug final rule (CMS-2345-FC)(81 FR 5170). As a result, TennCare has been using MSLC to implement and acquire pharmacy invoice level detail to determine a consistent, efficient, economical pharmacy drug reimbursement costs under the AAAC methodology. Since implementation TennCare continues to have tremendous partnership with the pharmacy community with a 96.7 percent pharmacy network participation rate.

The proposed amendment is requested to ensure TennCare's alignment with its State Plan Amendment (SPA) as governed by the Health Resources and Services Administration (HRSA) which requires reimbursement to 340B pharmacies for pharmaceuticals purchased through the 340B pricing program. To ensure that 340B pharmacy reimbursements are at or below the 340B ceiling price set by HRSA and maintain alignment with the Affordable Care Act (ACA) and HRSA requirements, the addition of 340B reporting, survey activities, and help desk support are necessary elements to ensure accuracies for 340B reimbursements and Federal Rebates.

Additionally, TennCare is requesting to extend the contracted actuarial services performed by MSLC to ensure ongoing maintenance of the State of Tennessee specific AAAC for the purposes of pharmacy reimbursement that follows federal requirements and to increase the maximum liability to accommodate the extension and proposed services for 340B compliance. This will continue to support continuity for the Tennessee pharmacies and our members.

12) Navigant Consulting, Inc. – Amendment #3: Navigant Consulting, Inc. (formerly Aon Consulting, Inc.) is the competitively procured Contractor that develops actuarially sound per capita costs on an annual basis to be used for compensating Managed Care Organization (MCO) participants within the Division of TennCare. The contract term included an initial three (3) year term with an additional three (3) one (1) year renewal options that the State may exercise. The proposed amendment is needed in order to exercise the contracts remaining renewal options plus an additional 12-months and increase the maximum liability accordingly for the proposed term extension.

13) Proteus, Digital Health, Inc. (New Contract): Proteus Digital Health is the sole innovator of digital pharmaceuticals and global leader in the digital pharmaceutical industry. Since 2001, Proteus Digital Health has secured more than 500 patents for both wearable and ingestible sensors for patient compliance monitoring.

Proteus Discover® for Infectious Disease includes the FDA-approved Proteus ingestible sensor and specialty pharmacy preparations of commercially available Hepatitis C, HIV and TB medicines, Proteus Patch® for sensing a patient's usage and response to therapy, and the Proteus Discover App and Proteus Discover Portal for patients and healthcare professionals to receive treatment management and intervention support.



The Proteus sensor and digital medicine platform is currently the only FDA-approved ingestible event marker and ingestion-based adherence management product available in the marketplace. There is no other provider who offers Hepatitis C ingestible digital medication to monitor patient compliance with Hepatitis C medications.

Hepatitis C medications are high-cost, but effective medications. At the end of a well-maintained regimen, the patient can be cured of Hepatitis C. The goal of this pilot is to improve health outcomes by tracking adherence to the Hepatitis C medications and therefore ensuring greater cure rates and to reduce over-utilization of these high-cost medications through a reduction in retreatments, greater patient autonomy over his or her care, and higher cure rates. If this pilot is successful, compliance should increase, allowing for expansion of this method.

TennCare respectfully submits the above referenced contract amendments for consideration and approval by the Fiscal Review Committee. We look forward to promptly providing any additional information as may be requested by the Committee.

Sincerely,

A handwritten signature in blue ink, appearing to read "William Aaron".

William Aaron
Chief Financial Officer

cc: Gabe Roberts, Director of TennCare

Amendment Request

This request form is not required for amendments to grant contracts. Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@tn.gov

APPROVED

CHIEF PROCUREMENT OFFICER

DATE

Agency request tracking #	31865-00372	
1. Procuring Agency	Department of Finance and Administration Division of TennCare	
2. Contractor	AMERIGROUP Tennessee, Inc.	
3. Edison contract ID #	40180	
4. Proposed amendment #	11	
5. Contract's Original Effective Date	January 1, 2014	
6. Current end date	December 31, 2020	
7. Proposed end date	December 31, 2020	
8. Current Maximum Liability or Estimated Liability	\$11,815,423,650.00	
9. Proposed Maximum Liability or Estimated Liability	\$11,815,423,650.00	
10. Strategic Technology Solutions Pre-Approval Endorsement Request – information technology service (N/A to THDA)	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
11. eHealth Pre-Approval Endorsement Request – health-related professional, pharmaceutical, laboratory, or imaging	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
12. Human Resources Pre-Approval Endorsement Request – state employee training service	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
13. Explain why the proposed amendment is needed		
<p>This competitively procured contract is being amended to provide relative changes to the managed care program including:</p> <ul style="list-style-type: none"> • CoverKids Implementation Requirements for January 1, 2021 Effective Date • Updated language to address CMS's Focused Program Integrity Review of Personal • Care Services and PI Investigator credentials • EVV Compliance changes to include changes to LDs • Clarifications around the new PCSP and Medication Risk Assessment Processes 		

Agency request tracking #	31865-00372
<ul style="list-style-type: none"> • Correcting weighting errors from prior cycles • Changes to required reporting for CHOICES and ECF CHOICES Advisory Groups • Additions of Beneficiary Support System training and education • Care Coordination and Support Coordination Changes as well as changes to monitoring requirements • Requirements for Contractors to collaborate with DIDD • ECF CHOICES Quality Monitoring Changes • WFD updates • Direct Service Worker Oversight and Monitoring • Requirements surrounding NCI and NCI-AD • Updates to member handbook requirements • Updates to Groups 7 & 8 reporting requirements • Update Population Health language to reflect current program • Clarifications to Turning 21 Transition requirements • Medication Assisted Treatment language updated to include Methadone requirements • Updated training requirements for PCMH, THL and EOC4 • Housekeeping updates to Reporting and Reporting Template requirements 	
<p>14. If the amendment involves a change in Scope, describe efforts to identify reasonable, competitive, procurement alternatives to amending the contract.</p> <p>This contract for the provision of medical and behavioral health services to the TennCare population was competitively procured. These changes to scope are necessary to make updates to the contract based on contract program changes to existing language and to ensure compliance with CMS regulations.</p>	
<p>Signature of Agency head or authorized designee, title of signatory, and date (the authorized designee may sign his or her own name if indicated on the Signature Certification and Authorization document)</p>	



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31865-00372	Edison ID 40180	Contract #	Amendment # 11		
Contractor Legal Entity Name AMERIGROUP Tennessee, Inc.			Edison Vendor ID 0000011035		
Amendment Purpose & Effect(s) Updates Scope– Statewide TennCare Managed Care					
Amendment Changes Contract End Date: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		End Date: December 31, 2020			
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):			N/A		
Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2014	\$0.00	\$0.00			\$0.00
2015	\$324,807,988.00	\$602,949,762.00			\$927,757,750.00
2016	\$660,871,832.00	\$1,226,794,068.00			\$1,887,665,900.00
2017	\$700,340,000.00	\$1,299,660,000.00			\$2,000,000,000.00
2018	\$687,900,000.00	\$1,312,100,000.00			\$2,000,000,000.00
2019	\$682,840,000.00	\$1,317,160,000.00			\$2,000,000,000.00
2020	\$682,840,000.00	\$1,317,160,000.00			\$2,000,000,000.00
2021	\$341,420,000.00	\$658,580,000.00			\$1,000,000,000.00
TOTAL:	\$4,081,019,820.00	\$7,734,403,830.00			\$11,815,423,650.00
Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.			<i>CPO USE</i>		
Speed Chart (optional)		Account Code (optional)			

**AMENDMENT NUMBER 11
STATEWIDE CONTRACT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
AMERIGROUP TENNESSEE, INC.**

EDISON RECORD ID: 40180

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contract by and between the State of Tennessee, Division of TennCare, hereinafter referred to as TENNCARE, and AMERIGROUP TENNESSEE, INC., hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

- 1. The first page of the Contract shall be amended by deleting and replacing the fourth and fifth paragraph as follows:**

WHEREAS, consistent with waivers granted by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to Health Maintenance Organizations (HMOs), referred to as Managed Care Organizations or MCOs, for rendering or arranging necessary physical health, behavioral health, and long-term care services to persons who are enrolled in Tennessee's TennCare program and health care coverage for uninsured children who are not eligible for TennCare coverage and are enrolled in CoverKids;

WHEREAS, the Tennessee Department of Finance and Administration is the state agency responsible for administration of the TennCare and CoverKids program and is authorized to contract with MCOs for the purpose of providing the services specified herein for the benefit of persons who are eligible for and are enrolled in the TennCare and CoverKids program; and

- 2. All references in this Contract to "Fraud and Abuse" shall be deleted and replaced with the phrase "Fraud, Waste, and Abuse". All references to "Medicaid Fraud Control Unit (TBI MFCU)" shall be deleted and replaced by "Medicaid Fraud Control Division (TBI MFCD).**

- 3. Section 1 shall be amended by adding the following definitions:**

CHIPRA - is defined as the Children's Health Insurance Program Reauthorization Act, a federal law.

CoverKids - the State Child Health Plan under Title XXI of the social Security Act State Children's Health Insurance Program.

CoverKids Pregnant Women - (formerly referred to as “CoverKids Pregnant Women/Unborn Children”). Provides coverage for the unborn children of pregnant women with no source of coverage, who meet the CoverKids eligibility requirements.

Group One Children - are CoverKids enrollees who are members of families with incomes between two hundred percent (200%) and two hundred fifty percent (250%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.

Group Two Children - are CoverKids enrollees who are members of families below two hundred percent (200%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.

4. Section 1 shall be amended by deleting and replacing the following definitions:

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program or the CoverKids program. As it relates to CHOICES and ECF CHOICES a person is eligible to receive CHOICES or ECF CHOICES benefits only if he/she has been enrolled in CHOICES or ECF CHOICES by TENNCARE.

Enrollee – A person who has been determined eligible for TennCare or CoverKids and who has been enrolled in the TennCare or CoverKids program (see Member, also). Synonymous with Member. For purposes of TennCare Enrollee Benefit Appeals and the TennCare Enrollee Benefit Appeal-related provisions in Section A.2.19 herein, “Enrollee” means (1) enrollee, (2) enrollee’s parent, (3) enrollee’s legal guardian, or (4) Enrollee-Authorized Representative. For purposes of provider agreements in Sections A.2.12.23, and missed visits of home health services in Section A.2.15.9, “Enrollee” means not only (1) the enrollee, (2) the enrollee’s parent, or (3) the enrollee’s legal guardian, but also a person who has a close, personal relationship with the enrollee and is routinely involved in providing unpaid support and assistance to them.

Enrollment – The process by which a TennCare or CoverKids enrollee becomes a member of the CONTRACTOR’s MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA ‘89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State’s Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B. In accordance with the CoverKids State Plan and Division of TennCare rules and regulations, EPSDT shall not apply to CoverKids members.

TennCare or TennCare Program – The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs. For purposes of the contract requirements herein, references to TennCare or the TennCare Program shall include CoverKids unless otherwise specified.

5. Section A.2.1.2 shall be deleted and replaced as follows:

A.2.1.2 Readiness Review

- 2.1.2.1 Prior to the start date of operations and any substantive program changes or amendments, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that it is able to meet the requirements of this Contract. This shall include the implementation of the CoverKids program as a part of this Contract for which services shall begin January 1, 2021.
- 2.1.2.2 The CONTRACTOR shall cooperate in a "readiness review" conducted by TENNCARE to review the CONTRACTOR's readiness to begin operations. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all requirements of this Contract as determined by TENNCARE.
- 2.1.2.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR. TennCare or CoverKids enrollees may not be enrolled with the CONTRACTOR until TENNCARE has determined that the CONTRACTOR is able to meet the requirements of this Contract.
- 2.1.2.4 If the CONTRACTOR is unable to demonstrate its ability to meet the requirements of this Contract, as determined by TENNCARE, within the time frames specified by TENNCARE, TENNCARE may terminate this Contract in accordance with Section E.14 of this Contract and shall have no liability for payment to the CONTRACTOR or may institute Immediate Sanctions as described in Section E.29 of this Contracts.

6. Section A.2.2 shall be amended by adding a new Section A.2.2.7 as follows:

- A.2.2.7 Effective January 1, 2021, the CONTRACTOR shall administer CoverKids benefits as described in this Contract. Requirements set forth in the Contract shall be inclusive of the CoverKids program unless otherwise specified in this Contract, including provisions related to services that are not specifically included as covered CoverKids services described in Section A.2.6.1.7. Section A.2.19 Grievances and Appeals of this Contract shall not apply to CoverKids. Review of CoverKids decisions shall be governed by TennCare Division rule 1200-13-21-.07 in accordance with T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

7. The Header labeled A.2.3 through Section A.2.3.2.3 shall be deleted and replaced as follows:

A.2.3 ELIGIBILITY FOR TENNCARE AND COVERKIDS

A.2.3.1 Overview

TennCare is Tennessee's Medicaid program operating under the authority of a research and demonstration project approved by the federal government pursuant to Section 1115 of the Social Security Act. CoverKids is the State Child Health Plan under Title XXI of the social Security Act

State Children’s Health Insurance Program. Eligibility for TennCare and CoverKids is determined by the State in accordance with federal requirements and state law and policy.

A.2.3.2 Eligibility Categories

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population (TennCare Standard). CoverKids consists of coverage groups (Group One Children) and (Group Two Children) as described below.

2.3.2.1 TennCare Medicaid

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.2.2 TennCare Standard

TennCare Standard includes the Standard Spend Down (SSD) population, the CHOICES At Risk Demonstration Group, CHOICES 217-Like HCBS Group, Interim ECF CHOICES At-Risk Demonstration Group, ECF CHOICES At-Risk Demonstration Group, ECF CHOICES 217-Like HCBS Group, ECF CHOICES Working Disabled Demonstration Group, and an expanded population of children. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.2.3 CoverKids

CoverKids includes children under age 19 and Mothers of unborn eligible who do not qualify for TennCare but meet the condition of “Group One Children” or “Group two Children”. CoverKids includes "Group One Children" who are enrollees who are members of families with incomes between two hundred percent (200%) and two hundred fifty percent (250%) of the federal poverty level (FPL) as reported by the State to the CONTRACTOR for the coverage period; and "Group Two Children" who are enrollees who are members of families below two hundred percent (200%) of FPL as reported by the State to the CONTRACTOR for the coverage period.

8. Section A.2.3.4 shall be amended as follows:

2.3.4 TennCare Applications

The CONTRACTOR shall not cause applications for TennCare or CoverKids to be submitted. However, as provided in Section A.2.9.6.3, the CONTRACTOR shall facilitate members’ eligibility determination for CHOICES and ECF CHOICES enrollment. The CONTRACTOR shall also conduct outreach and provide assistance as needed to members enrolled in CHOICES and ECF CHOICES in completing an annual renewal packet for eligibility redetermination. In addition, the CONTRACTOR shall be responsible for assisting members who have significant disabilities and/or complex medical needs and who have been determined by TENNCARE to no longer qualify for

Amendment 11 (cont.)

Medicaid in any other eligibility category in applying for Katie Beckett Part A or qualifying in the Katie Beckett Continued Eligibility Group, as applicable, and in accordance with processes and timelines established by TENNCARE.

9. Section A.2.6.1 shall be amended by adding the phrase “for TennCare Members (Excluding CoverKids)” to the Title of Section A.2.6.1.3 and by adding a new Section A.2.6.1.7 as follows:

2.6.1.7 CoverKids Benefits (Effective January 1, 2021)

SERVICE	BENEFIT LIMIT
Ambulance Services, Air and Ground	As medically necessary.
Chiropractic care	<p>Children Under Age 19: Maintenance visits not covered when no additional progress is apparent or expected to occur.</p> <p>Mothers (Age 19 and over) of Eligible Unborn Children: Not Covered</p>
Clinic Services and other Ambulatory Health Care Services	As medically necessary
Dental Services	<p>Dental Services shall be provided by the Dental Benefits Manager</p> <p>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist’s office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM</p>
Disposable Medical Supplies	<p>As medically necessary.</p> <p>Specified medical supplies shall be covered/non-covered in accordance with TennCare Division rules and regulations.</p>
Durable Medical Equipment (DME)	<p>Must be medically necessary. Durable medical equipment and other medically-related or remedial devices:</p> <p>Limited to the most basic equipment that will provide the needed care.</p> <p>Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter.</p> <p>Specified DME services shall be covered/non-covered in accordance with TennCare Division rules and regulations.</p>
Home Health Services	Prior approval required. Limited to 125 visits per enrollee per calendar year.

Amendment 11 (cont.)

SERVICE	BENEFIT LIMIT
Hospice Care	As medically necessary. Shall be provided by a Medicare-certified hospice.
Inpatient Hospital Services	As medically necessary, including rehabilitation hospital facility.
Inpatient Mental Health and Substance Abuse Services	As medically necessary.
Lab and X-ray Services	As medically necessary.
Outpatient Mental Health and Substance Abuse Services	As medically necessary.
Outpatient Hospital Services	As medically necessary.
Pharmacy Services	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section A.2.6.2.2).</p>
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.	Limited to 52 visits per calendar year per type of therapy.
Physician Inpatient Services	As medically necessary.

SERVICE	BENEFIT LIMIT
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary.
Prenatal care and pre-pregnancy family services and supplies	As medically necessary.
Preventive Care Services	As described in Section A.2.7.5.
Skilled Nursing Facility services	Limited to 100 days per calendar year following an approved hospitalization.
Surgical Services	As medically necessary.
Vision Services	<p>Children Under Age 19: Annual vision exam including refractive exam and glaucoma screening. Prescription eyeglass lenses. Limited to one pair per calendar year. \$85 maximum benefit per pair. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. \$100 maximum benefit per pair. 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. \$150 maximum benefit per pair.</p> <p>Mothers (Age 19 and over) of Eligible Unborn Children: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p>

10. Section A.2.6.7.1 shall be amended as follows:

2.6.7.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing or patient liability responsibilities for covered services except to the extent that cost sharing or patient liability responsibilities are required for those services by TENNCARE in accordance with TennCare Division rules and regulations, including but not limited to, not holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by

the State to the CONTRACTOR. Any cost sharing imposed on Medicaid enrollees shall be in accordance with Medicaid FFS requirements at 42 CFR 447.50 through 42 CFR 447.82. Further, the CONTRACTOR and all providers and subcontractors shall not charge enrollees for missed appointments.

11. Section A.2.6.7.3 shall be amended as follows:

2.6.7.3 Preventive Services

TennCare cost sharing or patient liability responsibilities shall apply to covered services other than the preventive services described in TennCare Division rules and regulations.

12. Section A.2.7.6.5 shall be deleted as all members are assessed for special health care needs in accordance with Sections A.2.9 and A.2.15 of this Contract.

13. Sections A.2.8.4 through A.2.8.12 shall be deleted and replaced as follows and all references shall be updated accordingly.

A.2.8.3 Program Content and Minimum Interventions

The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health Programs listed in Section A.2.8.1 of this Contract. Activities, interventions, and education objectives appropriate for members will vary for each program with increasing engagement and intensity as level of risk increases. All Population Health programs shall include the provisions of clinical reminders around HEDIS/gaps in care, and after-hours assistance with urgent or emergent member needs. The Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health programs will have a minimum standard set of interventions and frequency of touches but utilize varying modes of communication to attain the program objective. The CONTRACTOR shall develop and operate all Population Health programs using an “opt out” methodology. Population Health program services shall be provided to all eligible members unless they specifically ask to be excluded.

2.8.4.1 Wellness Program

For all eligible Level 0 members not pregnant the CONTRACTOR shall provide a **Wellness Program** with the objective of keeping members healthy.

2.8.3.1.1 The Wellness Program shall utilize educational materials and or activities that emphasize primary and secondary prevention.

2.8.3.1.2 The CONTRACTOR shall provide to members eligible for the Wellness Program self-management tools per PHM 4: Wellness and Prevention, as well as the following minimum intervention:

Wellness Program Minimum Intervention	
1.	One non-interactive educational quarterly touch to address the following within one year:
	<ul style="list-style-type: none"> A. How to be proactive in their health B. How to access a primary care provider C. Preconception and inter-conception health, to include dangers of becoming pregnant while using narcotics D. Age and/or gender appropriate wellness preventive health services (e.g., “knowing your numbers”) E. Assessment of special population needs for gaps in care (e.g., recommended immunizations for <i>children and adolescents</i>) F. Health promotion strategies (e.g., discouraging tobacco use and/or exposure, weight management, stress management, physical activity, substance abuse prevention) G. Healthy nutrition H. Other healthy and safe lifestyles

2.8.4.2 Low Risk Maternity Program

The CONTRACTOR shall provide a **Low Risk Maternity Program** for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications.

2.8.4.2.1 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the High Risk Maternity Program.

2.8.4.2.1.1 The CONTRACTOR shall provide to members eligible for the Low Risk Maternity Program the following minimum standard interventions:

Low Risk Maternity Program Minimum Interventions	
1.	Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract.
2.	One non-interactive intervention to the member for the duration of the pregnancy to include, at a minimum, information on pregnancy, newborn, and inter-conception health. A.
3.	Access number to appropriate support, to include a maternity nurse/social worker, when appropriate, if member would like to engage in sustained maternity management.
4.	Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required.
5.	Referrals to appropriate community-based resources and follow-up for these referrals.

2.8.4.3 Health Risk Management Program

For eligible Level 1 members, who are not pregnant, identified as designated in Section A.2.8.2.1.3.1 of this Contract, the CONTRACTOR shall provide a **Health Risk Management Program** designed to empower members to be proactive in their health and support the provider-patient relationship. The interventions provided in this program shall address the program’s goal of preventing, reducing or delaying exacerbation and complications of a condition or health risk behavior.

- 2.8.4.3.1 Health coaching or other interventions for health risk management shall emphasize self-management strategies addressing self-management tools per PHM 4: Wellness and Prevention (Element H), as well as self-monitoring, co-morbidities, cultural beliefs, and appropriate communication with providers.
- 2.8.4.3.2 The CONTRACTOR, through a Welcome Letter, shall inform members how to access and use services, and how to opt in or out of the program. The Welcome Letter may be used as the required non-interactive intervention if it includes all the required elements as detailed in Section A.2.8.4.3.5 of this Contract.
- 2.8.4.3.3 The CONTRACTOR shall provide, to members identified with weight management problems, education and support to address and improve this health risk. At the CONTRACTOR’s discretion the CONTRACTOR may also provide, as cost effective alternatives, weight management programs for Level 1 or 2 members identified as overweight or obese.
- 2.8.4.3.4 The CONTRACTOR shall provide, to members identified as users of tobacco, information on availability of tobacco cessation benefits, support and referrals to available resources such as the Tennessee Tobacco QuitLine.
- 2.8.4.3.5 The CONTRACTOR shall provide to members in the Health Risk Management Program the following minimum standard interventions:

Health Risk Management Program: Minimum Interventions	
1.	Four documented non-interactive communications each year. The communications shall address self-management education emphasizing the following: <ul style="list-style-type: none"> A. Increasing the members knowledge of chronic health conditions B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of health conditions E. Self-efficacy & support
2.	Offering of individual support for self-management if member desires to become engaged.
3.	Availability of 24/7 NurseLine.
4.	Availability of health coaching

2.8.4.4 Care Coordination Program

For all eligible members the CONTRACTOR shall provide a Care Coordination Program designed to help non-CHOICES members and non-ECF CHOICES members who may or may not have a chronic disease but have acute healthcare needs, health service needs, or risks which need immediate attention. The goal of the Care Coordination Program is to assure members get the services they need to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and should not be confused with CHOICES Care Coordination or ECF CHOICES Support Coordination. Services may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. Members receiving care coordination may be those members that were identified for, but declined complex case management.

2.8.4.5 Chronic Care Management Program

For all eligible Level 2 non-pregnant members, the CONTRACTOR shall provide a Chronic Care Management Program. The goal of the program is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self-management education and support.

2.8.4.5.1 The CONTRACTOR shall at a minimum make three outreach attempts to contact each newly identified member as eligible for Chronic Care Management to inform the member about the program. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.5.2 The CONTRACTOR shall provide to members enrolled in the Chronic Care Management Program the following minimum standard interventions:

Chronic Care Management Program Minimum Interventions	
1.	Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: <ul style="list-style-type: none">A. Development of a supportive member and health coach relationshipB. Disease specific management skills such as medication adherence and monitoring of the member's conditionC. Development and implementation of individualized care planD. Problem solving techniquesE. The emotional impact of member's conditionF. Self-efficacyG. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs

Amendment 11 (cont.)

2.8.4.5.3 The CONTRACTOR shall provide ongoing member assessment for the need to move these members into a lower risk classification or to the Complex Case Management Program for services.

2.8.4.6 **High Risk Maternity Program**

The CONTRACTOR shall provide a **High Risk Maternity Program** for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications.

2.8.4.6.1 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for the High Risk Maternity Program to inform the member about the program. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.6.2 The CONTRACTOR shall provide to members enrolled in the High Risk Maternity Program the following minimum standard interventions:

High Risk Maternity Program Minimum Interventions	
1.	One interactive contact to the member per month of pregnancy to provide intense case management including the following:
	Development of member support relationship by face to face visit or other means as appropriate.
	Monthly interactive contacts to support and follow-up on patient self-management. If prenatal visits have not been kept more frequent calls are required.
	Comprehensive HRA to include screening for mental health and substance abuse.
	Development and implementation of individualized care plan to include information on pregnancy, newborn, and inter-conception health.
	Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required.
	Referrals to appropriate community-based resources and follow-up for these referrals.
	If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including Tennessee Tobacco QuitLine.

2.8.4.7 Complex Case Management Program

The CONTRACTOR shall provide a **Complex Case Management Program** for eligible members, identified by criteria listed in Section A.2.8.2.1.4.2 of this Contract. The goal of the program is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support.

2.8.4.7.1 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for Complex Care Management to inform the member about the program. The outreach attempts shall be completed within the appropriate timeframes according to NCQA standard PHM 5 for complex case management. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. For those members where contact failed but appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.7.2 The CONTRACTOR shall develop and operate the Complex Case Management per NCQA standard PHM 5: Complex Case Management.

2.8.4.7.3 The CONTRACTOR shall provide to members enrolled in the Complex Case Management Program monthly interactive member contacts to provide individual self-management support.

A.2.8.4 Program Description

The CONTRACTOR shall develop and maintain a Population Health Program Strategy that meets or exceeds the NCQA standard PHM 1: PHM Strategy. The Division of TennCare requests an annual analysis of your PHM activities and any edits to your strategy, based on the data that was collected for the reporting year. At each MCOs discretion, the analysis required by NCQA may be submitted to TennCare to fulfill this requirement.

A.2.8.5 Clinical Practice Guidelines

Population Health programs shall utilize evidence-based clinical practice guidelines.

A.2.8.6 System Support and Capabilities

The CONTRACTOR shall maintain and operate a centralized information system necessary to conduct population health risk stratification. Systems recording program documentation shall meet NCQA Complex Case Management specifications and include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members, such as non-interactive and interactive touches as needed for follow-up confirmations and to determine intervention outcomes.

A.2.8.7 CHOICES and ECF CHOICES

The CONTRACTOR shall include CHOICES and ECF CHOICES members **and** dual eligible CHOICES and ECF CHOICES members when risk stratifying its entire population.

Amendment 11 (cont.)

- 2.8.7.1 The CONTRACTOR's Population Health Program Strategy shall include a CHOICES/ECF CHOICES section that describes how the organization integrates a CHOICES or ECF CHOICES member's information with other CONTRACTOR activities, including but not limited to, Utilization Management (UM), Health Risk assessment information, Health Risk Management and Chronic Care Management programs to assure programs are linked and enrollees receive appropriate and timely care.
- 2.8.7.2 The CONTRACTOR's CHOICES/ECF CHOICES section of the Population Health Strategy shall address how the CONTRACTOR shall ensure that, upon enrollment into CHOICES or ECF CHOICES, Health Risk Management or Chronic Care Management activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions and that the member's assigned Care Coordinator or Support Coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports, including appropriate management of chronic conditions. If a CHOICES or ECF CHOICES member has one or more chronic conditions, the member's Care Coordinator or Support Coordinator may use the CONTRACTOR's applicable Population Health Program's tools and resources, including staff with specialized training, to help manage the member's condition, and shall integrate the use of these tools and resources with care or support coordination. Population Health staff shall supplement, but not supplant, the role and responsibilities of the member's Care Coordinator/care coordination or Support Coordinator/support coordination team.
- 2.8.7.3 The CONTRACTOR's CHOICES/ECF CHOICES section of the Population Health Strategy shall also include the method for addressing the following for CHOICES or ECF CHOICES members:
 - 2.8.7.3.1 Notifying the CHOICES Care Coordinator or ECF CHOICES Support Coordinator of the member's participation in a Population Health Program;
 - 2.8.7.3.2 Providing member information collected to the CHOICES Care Coordinator or ECF CHOICES Support Coordinator;
 - 2.8.7.3.3 Provide to the CHOICES Care Coordinator or ECF CHOICES Support Coordinator any educational materials given to the member through these programs;
 - 2.8.7.3.4 Ensure that the Care Coordinator or Support Coordinator reviews Population Health educational materials verbally with the member and with the member's caregiver and/or representative (as applicable) and Coordinate follow-up that may be needed regarding the Population Health program, such as scheduling screenings or appointments with the CHOICES Care Coordinator or ECF CHOICES Support Coordinator;
 - 2.8.7.3.5 Ensure that the Care Coordinator or Support Coordinator integrates into the member's plan of care or PCSP, as applicable, aspects of the Population Health Program that would help to better manage the member's condition; and

Amendment 11 (cont.)

- 2.8.8.3.6 Ensure that the member's Care Coordinator or Support Coordinator shall be responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which shall be integrated into the member's plan of care or PCSP, as applicable, and which shall include monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which will help to better ensure management of the member's condition (see Section A.2.9.6 of this Contract).
- 2.8.7.4 As part of a Population Health Program, the CONTRACTOR shall place CHOICES and ECF CHOICES members into appropriate programs and/or stratification within a program, not only according to risk Level or other clinical or member-provided information but also by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The targeted interventions for CHOICES and ECF CHOICES members should not only be based on risk level but also based on the setting in which the member resides.
 - 2.8.7.4.1 Targeted methods for informing and educating CHOICES and ECF CHOICES members shall not be limited to mailing educational materials.
 - 2.8.7.5 The CONTRACTOR shall include CHOICES and ECF CHOICES process data in quarterly and annual reports as indicated in Section A.2.30.5 of this Contract. CHOICES and ECF CHOICES members will not be included in outcome measures in annual Population Health reports.
 - 2.8.7.6 The CONTRACTOR shall ensure that upon a member's enrollment in CHOICES or ECF CHOICES, if applicable, all High Risk Population Health Management CONTRACTOR activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator or Support Coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports needs. The Care Coordinator or Support Coordinator may use resources and staff from the CONTRACTOR's MCO Complex Case Management Program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's Care Coordinator/care coordination or Support Coordinator/support coordination team.
 - 2.8.7.7 The CONTRACTOR, in addition to requirements pertaining to nursing facility to community transitions (see Section A.2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home, shall provide coordination of care by the CHOICES Care Coordinator and the Population Health Complex Case Management staff:
 - 2.8.7.7.1 The member will be informed by CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;
 - 2.8.7.7.2 Within three (3) business days of a request to transition by or on behalf of a Group 1 member under age 21, the member will be referred by the CHOICES Care Coordinator to MCO Case Management for service identification and implementation in the home setting;

Amendment 11 (cont.)

- 2.8.7.7.3 The Population Health Complex Case Manager will be responsible for developing a service plan for the home setting;
- 2.8.7.7.4 The CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the Population Health Complex Case Management staff, the member and/or the member's parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until it is determined that the transition is not appropriate or until the plan is complete; and
- 2.8.8.7.5 Any EPSDT benefits needed by the child in the community as an alternative to nursing facility care, including medically necessary home health or private duty nursing, as applicable, shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and EPSDT benefits.

A.2.8.8 Evaluation

The CONTRACTOR shall collect and report process and outcome data as indicated on Population Health quarterly and annual report templates provided by TENNCARE.

14. Section A.2.9.4 shall be deleted and replaced as follows including, as appropriate, any references thereto.

A.2.9.4 Coordination and Collaboration for Members receiving Home Health or Private Duty Nursing Services

- 2.9.4.1 The CONTRACTOR shall actively engage all members receiving home health (HH) or private duty nursing (PDN) services, as defined in TennCare Rule 1200-13-13-.01, respectively, in excess of adult benefit limits and/or coverage criteria. The CONTRACTOR shall meet the following milestone requirements and provide documentation as required below, and as requested by TENNCARE, that the following milestones are met:
 - 2.9.4.1.1 For all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in preparation for and during the eighteenth (18th) year of age, the CONTRACTOR shall:
 - 2.9.4.1.1.1 Identify all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, at least two (2) months prior to the member turning eighteen (18) years of age.
 - 2.9.4.1.1.2 Create an internal mechanism to track and review all cases, including outreach and education, assessment and transition planning discussions and activities for members at or older than eighteen (18) years of age who are receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism should be able to provide status updates as requested and in the form and format determined by TENNCARE. The internal tracking mechanism shall include but is not limited to the following:
 - 2.9.4.1.1.2.1 Member Name;

Amendment 11 (cont.)

- 2.9.4.1.1.2.2 Demographics;
- 2.9.4.1.1.2.3 1915(c) HCBS waiver status;
- 2.9.4.1.1.2.4 Intellectual/Developmental Disability (I/DD) status;
- 2.9.4.1.1.2.5 Current number of hours of HH or PDN;
- 2.9.4.1.1.2.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;
- 2.9.4.1.1.2.7 Date of completed listed milestone as appropriate;
- 2.9.4.1.1.2.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached a brief description of why the CONTRACTOR was unable to complete listed milestone;
- 2.9.4.1.1.2.9 Member transition plan of care.
- 2.9.4.1.1.3 Complete internal re-assessment of skilled and unskilled hands-on care needs that includes input of member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, the re-assessment should address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs that qualify for PDN.
- 2.9.4.1.1.4 Complete an in-home or face-to-face visit with member and the member's family that includes but is not limited to the following topics:
 - 2.9.4.1.1.4.1 Provide information regarding aging into the adult benefit category;
 - 2.9.4.1.1.4.2 Re-address supported decision-making and legal issues (including, but not limited to competency, power of attorney, etc.) related to a member turning eighteen (18) years of age;
 - 2.9.4.1.1.4.3 Discuss any school-related transitions, if applicable;
 - 2.9.4.1.1.4.4 Provide education to member regarding TennCare HH and PDN benefits, including the adult HH and PDN benefit;
 - 2.9.4.1.1.4.5 Provide education on ECF CHOICES and CHOICES programs, unless the member is enrolled in a Section 1915(c) HCBS waiver;
 - 2.9.4.1.1.4.6 Assist, as needed with referral and intake/enrollment processes, as applicable for CHOICES or ECF CHOICES, unless the member is enrolled in a Section 1915(c) HCBS waiver and in such case, only as referred by TENNCARE.

Amendment 11 (cont.)

- 2.9.4.1.1.5 Provide a Semi-Annual report to TENNCARE demonstrating the completion of the above items required in Section A.2.9.4.1.1 for each applicable member. This report does not need to include the actual case notes referenced in Section A.2.9.4.1.1.2.8.
- 2.9.4.1.2 For all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in preparation for and during the nineteenth (19th) year of age, the CONTRACTOR shall:
 - 2.9.4.1.2.1 Identify all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, at least two (2) months prior to the member turning nineteen (19) years of age.
 - 2.9.4.1.2.2 Continue to track all members internally in accordance with Section A.2.9.4.1.1.2. Additionally, the CONTRACTOR's Care team shall have quarterly multidisciplinary care coordination reviews to discuss and provide status updates for all members at or older than nineteen (19) years of age receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism shall include but is not limited to the following:
 - 2.9.4.1.2.2.1 Member Name;
 - 2.9.4.1.2.2.2 Demographics;
 - 2.9.4.1.2.2.3 1915(c) HCBS waiver status;
 - 2.9.4.1.2.2.4 Intellectual/Developmental Disability (I/DD) status;
 - 2.9.4.1.2.2.5 Current number of hours of HH or PDN;
 - 2.9.4.1.2.2.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;
 - 2.9.4.1.2.2.7 Date of completed listed milestone as appropriate;
 - 2.9.4.1.2.2.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;
 - 2.9.4.1.2.2.9 Member transition plan of care.
 - 2.9.4.1.2.3 Complete in-home reassessment of skilled and unskilled hands-on care needs that incorporates input of member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, the re-assessment should address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs that qualify for PDN.
 - 2.9.4.1.2.4 Coordinate joint interdisciplinary face-to-face in-home visit including but not limited to the HH or PDN care coordinator and ECF CHOICES and CHOICES Care and Support

Amendment 11 (cont.)

Coordinator Team or Advocate unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the joint interdisciplinary face-to-face in-home visit shall be coordinated to include the member's Independent Support Coordinator rather than the ECF CHOICES and CHOICES Care and Support Coordinator Team.

- 2.9.4.1.2.5 Complete a face-to-face in-home visit with member and the member's family that includes but is not limited to the following topics:
 - 2.9.4.1.2.5.1 Provide education to members regarding TennCare HH and PDN benefits, including the adult HH and PDN benefit;
 - 2.9.4.1.2.5.2 Review of the Turning Twenty-One (21) Member Handbook and accompanying acknowledgment form;
 - 2.9.4.1.2.5.3 Review any pertinent clinical care plan with input from home care providers and PCP representatives.
 - 2.9.4.1.2.6 Provide a Semi-Annual report to TENNCARE demonstrating the completion of the above items required in Section A.2.9.4.1.2 for each applicable member. This report should not include the actual case notes referenced in Section A.2.9.4.1.2.2.8.
- 2.9.4.1.3 For all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in preparation for and during the first three (3) months of their twentieth (20th) year of age, the CONTRACTOR shall:
 - 2.9.4.1.3.1 Identify all members receiving HH or PDN services above the adult benefit limit at least one (1) month prior to the member turning twenty (20) years of age.
 - 2.9.4.1.3.2 Continue to track all members internally in accordance with Sections A.2.9.4.1.1.2 and A.2.9.4.1.2.2. Additionally, the CONTRACTOR's Care team will have monthly multidisciplinary care coordination reviews to discuss and provide status updates for all members at or older than twenty (20) years of age receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism shall include but is not limited to the following:
 - 2.9.4.1.3.2.1 Member Name;
 - 2.9.4.1.3.2.2 Demographics;
 - 2.9.4.1.3.2.3 1915(c) HCBS waiver status;
 - 2.9.4.1.3.2.4 Intellectual/Developmental Disability (I/DD) status;
 - 2.9.4.1.3.2.5 Current number of hours of HH or PDN;
 - 2.9.4.1.3.2.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;
 - 2.9.4.1.3.2.7 Date of completed listed milestone as appropriate;

Amendment 11 (cont.)

- 2.9.4.1.3.2.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;
- 2.9.4.1.3.2.9 Member transition plan of care.
- 2.9.4.1.3.3 Complete in-home reassessment of skilled and unskilled hands-on care needs that incorporates input of member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, the re-assessment should address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs that qualify for PDN.
- 2.9.4.1.3.4 Coordinate joint interdisciplinary face-to-face in-home visit including but not limited to the HH or PDN care coordinator and ECF CHOICES and CHOICES Care and Support Coordinator Team or Advocate unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the joint interdisciplinary face-to-face in-home visit shall be coordinated to include the member's Independent Support Coordinator rather than the ECF CHOICES and CHOICES Care and Support Coordinator Team.
- 2.9.4.1.3.5 Complete a face-to-face in-home visit with member and the member's family that includes but is not limited to the following topics:
 - 2.9.4.1.3.5.1 Provide education to members regarding TennCare HH and PDN benefits, including the adult HH and PDN benefit;
 - 2.9.4.1.3.5.2 Re-review of the Turning Twenty-One (21) Member Handbook and accompanying acknowledgment form;
 - 2.9.4.1.3.5.3 Determine and document any anticipated changes to the member's support plan/environment when turning twenty-one (21) and update ECF CHOICES person-centered support plan if already enrolled unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the CONTRACTOR shall work with the Independent Support Coordinator to update the member's Individual Support Plan;
 - 2.9.4.1.3.5.4 Review any pertinent clinical care plan with input from home care providers and PCP representatives;
- 2.9.4.1.3.6 Contact member's primary care provider and/or specialist to discuss member's benefit limit change and review the transition plan of care.
- 2.9.4.1.3.7 Provide a Semi-Annual report to TENNCARE demonstrating the completion of the above items required in Section A.2.9.4.1.3 for each member. This should not include the actual case notes referenced in Section A.2.9.4.1.3.2.8.
- 2.9.4.1.4 For all members age twenty (20) years six (6) months and older receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, the CONTRACTOR shall:

Amendment 11 (cont.)

- 2.9.4.1.4.1 Continue to track all members internally in accordance with Sections A.2.9.4.1.1.2, A.2.9.4.1.2.2, and A.2.9.4.1.3.2. Additionally, the CONTRACTOR's Care team will have weekly multidisciplinary care coordination reviews to discuss and provide status updates for all members at or older than twenty (20) years six (6) months of age receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism shall include but is not limited to the following:
- 2.9.4.1.4.1.1 Member Name;
 - 2.9.4.1.4.1.2 Demographics;
 - 2.9.4.1.4.1.3 1915(c) HCBS waiver status;
 - 2.9.4.1.4.1.4 Intellectual/Developmental Disability (I/DD) status;
 - 2.9.4.1.4.1.5 Current number of hours of HH or PDN;
 - 2.9.4.1.4.1.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN as defined in TennCare Rule 1200-13-13-.01 (101);
 - 2.9.4.1.4.1.7 Date of completed listed milestone as appropriate;
 - 2.9.4.1.4.1.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;
 - 2.9.4.1.4.1.9 Member transition plan of care.
- 2.9.4.1.4.2 At least monthly include the care coordination team of the prospective MCO of the member in the multidisciplinary care coordination reviews.
- 2.9.4.1.4.3 Re-evaluate all members and confirm if member is considering CHOICES or ECF CHOICES, unless the member is enrolled in a Section 1915(c) HCBS waiver.
- 2.9.4.1.4.3.1 For members receiving HH or PDN services above the adult benefit limit and/or coverage criteria considering home and community based services CHOICES or ECF CHOICES the CONTRACTOR shall contact LTSS within five (5) business days of discovery that a member is above such limit and/or coverage criteria to discuss transition of the member, unless the member is enrolled in a Section 1915(c) HCBS waiver. This shall include but is not limited to discussing and initiating the intake process for CHOICES or ECF CHOICES. For CHOICES group 2 or 3, the member cannot enroll until age twenty-one (21) but the MCO can complete a person-centered support plan (PCSP) with the member/family to demonstrate what services will be provided. For ECF CHOICES, enrollment can occur earlier and allows the member to initiate some ECF CHOICES services and also begin the process of hiring CD workers if they choose that option.
- 2.9.4.1.4.4 For members not willing to transition to HH and/or PDN services, as applicable, that comport with adult benefit limits upon turning age 21, and considering home and

Amendment 11 (cont.)

community based CHOICES or ECF CHOICES and not enrolled in a Section 1915(c) HCBS waiver, or alternatively, enrolled in a Section 1915(c) HCBS waiver, but not participating with the CONTRACTOR and the Independent Support Coordinator to make needed adjustments in the member's Individual Support Plan:

- 2.9.4.1.4.4.1 Require the Medical Director (or equivalent) to conduct peer-to-peer review with the member's PCP of the care plan;
- 2.9.4.1.4.4.2 Develop and provide a proposed plan that outlines how the services within CHOICES/ECF CHOICES program, in combination with medically necessary covered home health or private duty nursing for adults age 21 and older, as applicable, could support the member in lieu of current skilled or home health services, and in the case of a person enrolled in a Section 1915(c) HCBS waiver, in lieu of 1915(c) waiver services as well. The proposed plan will be developed based on the member's current diagnosis, medical and behavioral needs and not considered final. A complete CHOICES/ECF CHOICES assessment and development of the person centered support plan would occur should the member choose to enroll in the CHOICES/ECF CHOICES program, which for a person enrolled in a Section 1915(c) HCBS waiver would require disenrollment from that waiver program;
- 2.9.4.1.4.4.3 If the member is enrolled in a Section 1915(c) HCBS waiver, but not participating with the CONTRACTOR and the Independent Support Coordinator to make needed adjustments in the member's Individual Support Plan, work with the Independent Support Coordinator to develop proposed updates to the member's Individual Support Plan that could, in combination with medically necessary covered home health or private duty nursing for adults age 21 and older, as applicable, support the member in lieu of current skilled or home health services. The proposed plan will be developed based on the member's current diagnosis, medical and behavioral needs and shall not be considered final. Updates could be finalized with the member and his/her Circle of Support in order to facilitate timely transition to adult benefits; and
- 2.9.4.1.4.4.4 Maintain detailed documentation of all contacts and activities described in this section, including efforts to educate the member and family, and to engage them in planning for the member's transition to adult benefit limits and the development of home and community based services (and other alternatives, as applicable) that could support the member in lieu of current skilled or home health services; and provide monthly reports to TENNCARE for each member outlining continued engagement, assessments, transition planning discussions and activities, reduction status and supporting documentation. The report shall also include clinical assessment documenting whether the patient is ventilator dependent or has a tracheostomy or other complex respiratory care needs that qualify for PDN and current skilled nursing needs.
- 2.9.4.1.4.5 Provide TENNCARE with a weekly report that identifies member name, identifying information and selected MCO. At TENNCARE's discretion, the report should contain at least the following elements:
 - 2.9.4.1.4.5.1 Member name;
 - 2.9.4.1.4.5.2 Demographics;

Amendment 11 (cont.)

- 2.9.4.1.4.5.3 1915(c) HCBS waiver status;
- 2.9.4.1.4.5.4 Intellectual/Developmental Disability (I/DD) status
- 2.9.4.1.4.5.5 Initial MCO choice (at 20 ½ years of age);
- 2.9.4.1.4.5.6 If no patient choice, auto assigned MCO at 20 ½ years of age;
- 2.9.4.1.4.5.7 Transition plan (Yes/No);
- 2.9.4.1.4.5.8 MCO assignment at 20 years and 9 months of age;
- 2.9.4.1.4.5.9 “In-person” meeting between TCS and assigned MCO regarding the impending transition;
- 2.9.4.1.4.5.10 Date of change for MCO assignment since last report, if applicable.
- 2.9.4.1.5 For all members who are enrolled in TennCare Select receiving HH or PDN services, in excess of adult benefit limits and/or coverage criteria, as applicable, between the ages of twenty (20) years three (3) months of age and twenty-one (21) years of age and have been identified for potential prospective assignment to CONTRACTOR, the CONTRACTOR shall:
 - 2.9.4.1.5.1 Coordinate and participate in joint face-to-face introduction and meeting with member and member’s family, TennCare Select care team and prospective MCO CONTRACTOR care team shall occur no later than the member being twenty (20) years and six (6) months of age.
 - 2.9.4.1.5.2 To begin no later than the member being twenty (20) years and six (6) months of age, participate at least monthly in multidisciplinary care coordination reviews between prospective MCO CONTRACTOR care coordination team and TennCare Select care coordination team.
 - 2.9.4.1.5.3 Provide documentation, at the request of TENNCARE and in the form and format determined by TENNCARE, from the prospective MCO CONTRACTOR that includes but is not limited to the following information:
 - 2.9.4.1.5.3.1 Member Name;
 - 2.9.4.1.5.3.2 Demographics;
 - 2.9.4.1.5.3.3 Current number of hours of HH or PDN;
 - 2.9.4.1.5.3.4 Ventilator or tracheostomy dependent, or other complex respiratory care needs;
 - 2.9.4.1.5.3.5 Date of completed listed milestone as appropriate;

Amendment 11 (cont.)

- 2.9.4.1.5.3.6 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why CONTRACTOR was unable to complete listed milestone;
- 2.9.4.1.5.3.7 Member transition plan of care.
- 2.9.4.1.6 For all members receiving HH or PDN services, in excess of adult benefit limits and/or coverage criteria, as applicable, that are eighteen (18), nineteen (19) or twenty (20) years of age during the implementation of the requirements in Sections A.2.9.4.1.1 through A.2.9.4.1.5, the CONTRACTOR shall perform the requirements for the member's respective age within six (6) months of January 1, 2018. However, the CONTRACTOR shall not be required to perform the requirements applicable to the ages younger than the member. By way of example, if a member is nineteen (19) years of age during the first year of implementation of the requirements in Sections A.2.9.4.1.1 through A.2.9.4.1.5, within six (6) months the CONTRACTOR shall perform the requirements applicable in a member's nineteenth (19th) year of age per Section A.2.9.4.1.2 but is not required to perform the requirements applicable in a member's eighteenth (18th) year of age per Section A.2.9.4.1.1.
- 2.9.4.1.7 For any member receiving HH or PDN services, in excess of adult benefit limits and/or coverage criteria, as applicable, that is twenty-one (21) years of age or older after the implementation of Sections A.2.9.4.1.1 through A.2.9.4.1.5 the CONTRACTOR shall perform the following requirements within fifteen (15) months of implementation of said requirements:
 - 2.9.4.1.7.1 Identify all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria.
 - 2.9.4.1.7.2 Create internal mechanism to track and review all cases, including outreach and education, assessment and transition planning discussions and activities for members who are receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism should be able to provide status updates as requested and in the form and format determined by TENNCARE. The internal tracking mechanism shall include but is not limited to the following:
 - 2.9.4.1.7.2.1 Member Name;
 - 2.9.4.1.7.2.2 Demographics;
 - 2.9.4.1.7.2.3 Current number of hours of HH or PDN;
 - 2.9.4.1.7.2.4 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;
 - 2.9.4.1.7.2.5 Date of completed listed milestone as appropriate;
 - 2.9.4.1.7.2.6 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;

Amendment 11 (cont.)

- 2.9.4.1.7.2.7 Member transition plan of care.
- 2.9.4.1.7.3 Complete the requirements of Section A.2.9.4.1.2.5.
- 2.9.4.1.7.4 Complete the requirements of Section A.2.9.4.1.3.5.
- 2.9.4.1.7.5 At the sole discretion of TENNCARE, an On Request Report (ORR) may be issued to the CONTRACTOR to obtain information for review by TENNCARE prior to the CONTRACTOR issuing an adverse benefit determination (ABD), reducing PDN and/or HH for any member age twenty-one (21) years old or older receiving PDN and/or HH services in excess of adult benefit limits and/or coverage criteria.
- 2.9.4.1.7.6 The ORR from TENNCARE may include requests for information and documentation, including but not limited to, transition planning discussions, nursing notes, home health aide notes, assessments, current plan of care, alternative plans of care, and information regarding missed shifts.
- 2.9.4.1.8 For all members eighteen (18) years of age or older who are receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in compliance with an Administrative Law Judge's (ALJ) order or provided as a cost-effective alternative (CEA), the CONTRACTOR shall perform the following requirements:
 - 2.9.4.1.8.1 Identify the applicable member.
 - 2.9.4.1.8.2 Fulfill the requirements in Contract Section A.2.9.4.1 for these members.
 - 2.9.4.1.8.3 Six (6) months after the ALJ order or the determination of the cost-effective alternative and every six (6) months thereafter, complete internal re-assessment of skilled and unskilled hands-on care needs that includes input from the member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, this re-assessment shall address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs.
 - 2.9.4.1.8.4 The CONTRACTOR's Medical Director (or equivalent) shall conduct peer-to-peer review with the member's PCP of the care plan, determine if the member's clinical status has changed, the appropriateness of the ALJ ordered services, and/or whether the service still qualifies as a cost-effective alternative. Depending on the CONTRACTOR's determination, the CONTRACTOR shall take the appropriate action.
 - 2.9.4.1.8.5 Provide TENNCARE with a Semi-Annual report demonstrating the above items required in section A.2.9.4.1.8 for each applicable member.

15. Section A.2.9.6.2.5.10 shall be amended as follows:

- 2.9.6.2.5.10 As part of the face-to-face visit for members in CHOICES Group 3, the Care Coordinator shall provide explanation to the member regarding the fifteen thousand dollar (\$15,000) expenditure cap and make a determination whether the member's needs can be safely met

Amendment 11 (cont.)

within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers and make a determination whether the member's need can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers;

- 2.9.6.2.5.10.1 If the member has been approved for At-Risk level of care and expressed interest in enrollment into CHOICES Group 3 and is in a nursing facility, the Care Coordinator shall work with the nursing facility to coordinate timely transition to the community, enrollment into CHOICES Group 3, and initiation of CHOICES HCBS.
- 2.9.6.2.5.10.2 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the array of services and supports that would be available as described in Section A.2.9.6.2.5.10 the Care Coordinator shall, in a manner prescribed by TENNCARE, complete a *Safety Determination Request Form*, including all required documentation as required by TENNCARE, and coordinate with TENNCARE to review the member's level of care, and if nursing facility level of care is approved, to facilitate transition to CHOICES Group 1 or 2.

16. Section A.2.9.6.6.2.4 shall be amended as follows:

- 2.9.6.6.2.4 When developing the PCSP for CHOICES and ECF CHOICES members, the CONTRACTOR shall comply with federal rules at 42 C.F.R. § 441.301(c) pertaining to person-centered planning and shall use the PCSP template required by TENNCARE. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of choice and supported decision-making, and shall meet PCSP quality standards as specified by TENNCARE. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential positive and negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, when appropriate, which shall be documented in the PCSP as appropriate. The PCSP at a minimum shall include:

17. Section A.2.9.6.6.2.4.5.1 shall be amended as follows:

- 2.9.6.6.2.4.5.1 All Care Coordinators and Support Coordinators shall, in consultation with interdisciplinary team experts, as needed (see 2.9.6.6.2.2), complete a Medication Risk Assessment for all members receiving HCBS in CHOICES or ECF CHOICES except members electing and currently receiving hospice services, as prescribed or approved by TennCare, to assess the level of medication complexity and risk to the member due to medication errors. The Medication Risk Assessment shall include but is not limited to the total number of medications the member takes, complexity of medication regimens, frequent changes in medications (new, changed, or discontinued medications), prescribed

"high-risk" medications (those having a high risk of causing patient harm and even death when used incorrectly, including but not limited to anti-coagulants, insulin, narcotics, inhalers (excluding albuterol), opiates, sedatives, and anti-arrhythmic), cognitive or physical limitations impacting self-administration of medications, and the availability of natural or paid supports to assist with medication administration (including set-up, reminders, etc.). For any member who scores in the high-risk category on this assessment, Care Coordinators and Support Coordinators shall, in consultation with interdisciplinary team experts, as needed: (1) identify in the PCSP appropriate strategies to support the member's administration of medication and minimize potential risk, which may include but are not limited to medication reconciliation, patient and family education or the use of assistive technology; and (2) review on an ongoing basis to assess the efficacy of these strategies in reducing medication risk and to identify additional supports, as needed.

- 18. Section A.2.9.6.6.2.5 shall be amended as follows and Section A.2.9.6.10 shall be amended by deleting and replacing Sections A.2.9.6.10.4.3.12 and A.2.9.6.10.4.3.13, by adding a new Section A.2.9.6.10.4.3.15 and renumbering the remaining Section accordingly, including any references thereto.**

2.9.6.6.2.5 The member's Care Coordinator/Care Coordination or Support Coordinator/Support Coordination team, as applicable shall ensure that the member or his/her representative, as applicable, reviews, signs and dates the PCSP, as applicable, as well as any substantive updates, including but not limited to any changes in the amount, duration or type of HCBS that will be provided. The member or his/her representative, as applicable, may sign the PCSP, as well as any substantive updates, electronically based on the member or representative's preference and only when the CONTRACTOR has completed the PCSP via a face-to-face person-centered planning process. A face-to-face visit shall not be required in order to complete minor corrections and updates, such as changes in the schedule at which services are needed. The Care Coordinator or Support Coordinator, as applicable, shall also sign and date the PCSP, as applicable, along with any substantive updates. The PCSP, as applicable, shall be updated and signed by the member or his/her representative, as applicable, and the Care Coordinator or Support Coordinator annually and any time the member experiences a significant change in needs or circumstances (see Section A.2.9.6.10.2.1.17). The Care Coordinator or Support Coordinator shall assess the experience of each member receiving Medicaid HCBS using the Individual Experience Assessment (IEA) as prescribed by TENNCARE: 1) upon initial service initiation 2) as part of the member's annual PCSP review; 3) within 30 days of a change in the mental or physical status of a member that impacts modifications/restrictions in place, as applicable; and 4) anytime a change in residence or provider occurs for a person receiving residential services (including, but not limited to, Community Living Services). In the case of items (1) and (4) above, the IEA shall be completed at the next monthly face-to-face visit (as prescribed in A.2.9.6.10.4.3.15), unless such visit is less than two weeks following the initiation of services in item (1) or the change in residence in provider in item (4), in which case, the IEA shall be completed at the following monthly face-to-face visit. A new IEA is not required when a person continues to receive the same benefit in the same residence from the same provider, even if the level of reimbursement for that service has changed. Nor is an IEA required if a person is receiving services in a time-limited transitional placement, pending transition to a more permanent living arrangement, provided that the CONTRACTOR remains obligated to ensure full

Amendment 11 (cont.)

compliance with the federal HCBS Settings Rule in all settings. Any restrictions must follow prescribed person-centered planning processes in the federal HCBS Settings Rule, and be reviewed by the CONTRACTOR's HCBS Settings Committee. All members receiving HCBS must have an IEA completed during a face-to-face visit at least annually. If the CONTRACTOR completes an IEA due to one of the circumstances described in items (3) or (4) above, the next IEA shall be due within one year from the date it is completed, unless an additional change as described in either items (3) or (4) occurs prior to that time. Participants in the IEA shall include the member and his or her family members and/or representative, as appropriate. Service provider staff may participate as requested by the member and his or her family and/or representative. In addition, the member's Care Coordinator or Support Coordinator, as applicable, shall address any issues regarding compliance with the HCBS Settings Rule or other concerns identified during the IEA within thirty (30) days of discovery. Additionally, a member's Care Coordinator or Support Coordinator, as applicable, shall complete the Employment Data Sheet (EDS) within thirty (30) days of a member's initiation of competitive integrated employment and annually, as provided by TENNCARE. The Employment Data Sheet may be completed telephonically by a member's Care or Support Coordinator, as applicable.

- 2.9.6.10.4.3.12 Except as provided in A.2.9.6.10.4.3.15, members in ECF CHOICES Group 5, shall be contacted by their Support Coordinator in person or by telephone at least monthly (i.e., the member's Support Coordinator must complete each subsequent contact within thirty (30) calendar days of the previous contact). These members shall be visited in their residence face-to-face by their Support Coordinator at least quarterly (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within ninety (90) calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.
- 2.9.6.10.4.3.13 Except as provided in A.2.9.6.10.4.3.15, members in ECF CHOICES Group 6 determined by an objective assessment to have low to moderate need and not to have exceptional medical or behavioral needs shall be contacted by their Support Coordinator at least monthly either in person or by telephone (i.e., the member's Support Coordinator must complete each subsequent in person or telephone contact within thirty (30) calendar days of the previous contact). These members shall be visited in their residence face-to-face by their Support Coordinator at least bi-monthly (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within sixty (60) calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.
- 2.9.6.10.4.3.15 Members in ECF CHOICES Group 5 or 6 receiving community-based residential alternative services, including community living supports and community living supports-family model, shall also be visited in their residence face-to-face by their

Support Coordinator at least monthly (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit) to ensure that the PCSP is being followed and that the PCSP continues to meet the member's needs, unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's PCSP, based on a significant change in circumstances (see Section A.2.9.6.10.2.1.17).

19. Section A.2.9.6.12.9.6 shall be amended deleting and replacing Sections A.2.9.6.12.9.6.6 and A.2.9.6.12.9.6.7 as follows:

2.9.6.12.9.6.6 ECF CHOICES Group 7 members shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of six (6).

2.9.6.12.9.6.7 ECF CHOICES Group 8 members shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of six (6).

20. Section A.2.9.6.12.21 shall be deleted and replaced as follows, including renumbering the remaining Sections accordingly, including any references thereto.

2.9.6.12.21 The CONTRACTOR shall provide initial training to newly hired Care Coordinators and ongoing training to Care Coordinators. Initial training topics shall include at a minimum:

2.9.6.12.21.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

2.9.6.12.21.2 Facilitating CHOICES enrollment for current members;

2.9.6.12.21.3 Level of care and comprehensive assessment and reassessment, development of a person-centered PCSP, and updating the PCSP including training on the tools and protocols;

2.9.6.12.21.4 Development and implementation of back-up plans;

2.9.6.12.21.5 Risk assessment and incorporating identified risk and risk mitigation strategies into the member's PCSP;

2.9.6.12.21.6 Consumer direction of eligible CHOICES HCBS;

2.9.6.12.21.7 Self-direction of health care tasks;

2.9.6.12.21.8 Coordination of care for duals;

2.9.6.12.21.9 Electronic visit verification;

2.9.6.12.21.10 Conducting a home visit and use of the monitoring checklist;

2.9.6.12.21.11 How to immediately identify and address service gaps;

Amendment 11 (cont.)

- 2.9.6.12.21.12 Management of critical transitions (including hospital discharge planning);
- 2.9.6.12.21.13 Nursing facility diversion;
- 2.9.6.12.21.14 Nursing facility to community transitions, including training on tools and protocols;
- 2.9.6.12.21.15 Management of transfers between nursing facilities and CBRA, including adult care homes, community living supports, and community living supports-family model;
- 2.9.6.12.21.16 Facilitation of transitions between CHOICES Groups;
- 2.9.6.12.21.17 For all CHOICES members, as applicable, members' responsibility regarding patient liability, including the consequences of not paying patient liability;
- 2.9.6.12.21.18 Alzheimer's, dementia and cognitive impairments;
- 2.9.6.12.21.19 Traumatic brain injury;
- 2.9.6.12.21.20 Physical disabilities;
- 2.9.6.12.21.21 Population health;
- 2.9.6.12.21.22 Behavioral health;
- 2.9.6.12.21.23 Evaluation and management of risk;
- 2.9.6.12.21.24 Identifying and reporting abuse/neglect (see Section A.2.25.4);
- 2.9.6.12.21.25 Critical incident reporting (see Section A.2.15.7);
- 2.9.6.12.21.26 Fraud and abuse, including reporting fraud and abuse;
- 2.9.6.12.21.27 Advance directives and end of life care;
- 2.9.6.12.21.28 HIPAA/HITECH;
- 2.9.6.12.21.29 Cultural competency;
- 2.9.6.12.21.30 Disaster planning;
- 2.9.6.12.21.31 Available community resources for non-covered services;
- 2.9.6.12.21.32 Information on the beneficiary support system, including but not limited to how to obtain assistance with choice counseling, filing complaints or appeals, finding the status of a complaint or appeal, and resolving issues related to rights and responsibilities;
- 2.9.6.12.21.33 The Care Coordinator's role and responsibility in assessing members who have been approved for At-Risk level of care, and have expressed interest in enrollment into

Amendment 11 (cont.)

CHOICES Group 3, and coordinating with the nursing facility to facilitate timely transition, enrollment into CHOICES Group 3, and initiation of HCBS when appropriate;

2.9.6.12.21.34 The Care Coordinator's role and responsibility in facilitating denial of enrollment into or termination of enrollment from CHOICES Groups 2 or 3 when a determination has been made that the applicant or member (as applicable) cannot be safely served within the member's cost neutrality cap (CHOICES Group 2) or Expenditure Cap (CHOICES Group 3); and

2.9.6.12.21.35 The Care Coordinator's role and responsibility in facilitating access to other medically TennCare covered benefits, including home health and behavioral health services.

21. Sections A.2.9.6.13.1 through A.2.9.6.13.4 shall be deleted and replaced as follows and renumbering accordingly, including any references thereto.

2.9.6.13.1 The CONTRACTOR shall develop and submit to TENNCARE for review and approval a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination and support coordination processes, including ongoing quality reviews of an acceptable volume of PCSPs for each care/support coordinator to ensure accuracy, completeness, quality and consistency with quality standards as specified by TENNCARE. The CONTRACTOR shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediation to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination and support coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. The CONTRACTOR shall provide detailed information regarding its care/support coordination monitoring processes in a form and format specified by TENNCARE (see A.2.30.6.7 and A.2.30.6.8. At a minimum, the CONTRACTOR shall ensure that:

2.9.6.13.1.1 PCSPs are accurate, complete, and have sufficient information to guide the delivery of person-centered supports for the member;

2.9.6.13.1.2 Assessment and planning processes are person-centered, and conform with best practices and with quality standards as specified by TENNCARE;

2.9.6.13.1.3 Care coordination and support coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;

2.9.6.13.1.4 Level of care assessments and level of care reassessments occur on schedule and are submitted to TENNCARE in accordance with requirements in Section A.2.9.6.10.3.1.1;

2.9.6.13.1.5 Comprehensive assessments and reassessment, as applicable, occur on schedule and in compliance with this Contract;

2.9.6.13.1.6 PCSPs for CHOICES and ECF CHOICES members are developed and updated on schedule and in compliance with this Contract;

Amendment 11 (cont.)

- 2.9.6.13.1.7 PCSPs for CHOICES and ECF CHOICES members reflect needs identified in the comprehensive assessment and reassessment process;
- 2.9.6.13.1.8 PCSPs for CHOICES and ECF CHOICES members are appropriate and adequate to address member needs;
- 2.9.6.13.1.9 Services are delivered as described in the plan of care or PCSP and authorized by the CONTRACTOR;
- 2.9.6.13.1.10 Services are appropriate to address the member's needs;
- 2.9.6.13.1.11 Services are delivered in a timely manner;
- 2.9.6.13.1.12 Service utilization is appropriate;
- 2.9.6.13.1.13 Service gaps are identified and addressed in a timely manner;
- 2.9.6.13.1.14 Minimum Care Coordinator and Support Coordinator contacts are conducted;
- 2.9.6.13.1.15 Care coordinator-to-member and Support Coordinator-to-member ratios are appropriate;
- 2.9.6.13.1.16 The cost neutrality cap for members in CHOICES Group 2 and the expenditure cap for members in CHOICES Group 3 and ECF CHOICES are monitored and appropriate action is taken if a member is nearing or exceeds his/her cost neutrality or expenditure cap; and
- 2.9.6.13.1.17 Benefit limits are monitored and appropriate action is taken if a member is nearing or exceeds a benefit limit.
- 2.9.6.13.2 The CONTRACTOR shall provide to TENNCARE the reports required by Section A.2.30.
- 2.9.6.13.3 The CONTRACTOR shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Contract, with policies and protocols established by TENNCARE, and with the requirements of the 21st Century Cures Act, which requires electronic (not manual) verification of the type of service performed, the individual receiving the service, the date of the service, location of service delivery, the individual providing the service, and time the service begins and ends. The CONTRACTOR shall notify TENNCARE within five (5) business days of the identification of any issue affecting EVV system operation which impacts the CONTRACTOR's performance of this Contract, including actions that will be taken by the CONTRACTOR to resolve the issue and the specific timeframes within which such actions shall be completed.
- 2.9.6.13.4 The CONTRACTOR shall monitor all manual confirmations and take action to eliminate manual confirmations to ensure compliance with 21st Century Cures Act EVV system requirements by January 1, 2020, and on an ongoing basis, and to assure overall program integrity and that members are receiving necessary services. At minimum, the

CONTRACTOR shall conduct audits and generate reports as prescribed by TENNCARE, including the report in Section A.2.30 of this Contract regarding manual confirmation, and shall monitor and take appropriate remedial action against providers and workers who repeatedly fail to use the EVV system when required to do so. The CONTRACTOR shall not deny payment to providers for services provided except upon written direction or approval from TENNCARE.

22. Section A.2.9.16.5 shall be amended as follows:

- 2.9.16.5 Tennessee Department of Intellectual Disabilities Services (DIDD), for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, and for purposes of ECF CHOICES, including intake, critical incident reporting and management, and quality monitoring. In addition, the CONTRACTOR shall partner with TENNCARE and DIDD to;
 - 2.9.16.5.1 Embed person-centered thinking, planning, and practices and align key requirements and processes across Medicaid programs and authorities in order to create a single, seamless person-centered system of service delivery for people with I/DD, including: critical incident management, quality assurance and improvement, direct support workforce training and qualifications, provider qualifications and enrollment/credentialing processes, value-based reimbursement approaches aligned with system values and outcomes;
 - 2.9.16.5.2 Increase the capacity, competency and consistency of the direct support workforce, including a reduction in workforce turnover and the ability to consistently demonstrate compliance in the timely initiation of services and the ongoing provision of services as specified in the person-centered support plan;
 - 2.9.16.5.3 Support the independence, integration, and competitive, integrated employment of individuals with I/DD through the use of effective person-centered planning, enabling technology, and the development of natural supports, including the implementation of a Technology First approach across the CHOICES and ECF HCBS programs; training and support for care and support coordinators in person-centered assessment and planning for independence; engaging occupational and physical therapists and/or certified Assistive Technology Professionals, as needed, as a member of the care team (whether contracted or employed by the CONTRACTOR) to provide in-home assessments and recommendations pertaining to the use of technology to support safety, independence and integration; displacement prevention; and supporting transformation of contracted providers to a Technology First approach in providing services and supports;
 - 2.9.16.5.4 Build the statewide capacity and continuum of the behavioral health system to meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavior support needs in a person-centered way (moving toward independence and integration to the maximum extent appropriate), including:
 - 2.9.16.5.4.1 The successful implementation of Groups 7 and 8 in Employment and Community First CHOICES;

Amendment 11 (cont.)

- 2.9.16.5.4.2 The development and engagement of statewide HCBS provider networks, including workforce capacity, to serve people with I/DD and co-occurring behavior support needs;
- 2.9.16.5.4.3 The development of statewide capacity for behavioral crisis response and stabilization, leveraging telehealth with in-person backup as needed;
- 2.9.16.5.4.4 The development of statewide capacity for rapid placement, stabilization and assessment, including person-centered transition planning with the HCBS provider and/or family caregiver (as applicable); program development and implementation (including training), and post-transition stabilization placement support (telehealth and in-person);
- 2.9.16.5.4.5 Observation, and upon request and as appropriate, participation in DIDD Human Rights Committee and likewise, inviting DIDD to observe and as appropriate, participate in the CONTRACTOR's HCBS Settings Compliance Committee to promote learning and a consistent person-centered approach to reviewing restrictions in PCSPs; and
- 2.9.16.5.4.6 Other opportunities for collaboration as determined by TENNCARE in order to develop and enhance the service delivery system for individuals with I/DD, improve person-centered outcomes, and provide services in a cost-efficient manner.

23. Section A.2.10 shall be amended as follows:

A.2.8 SERVICES NOT COVERED

Except as authorized pursuant to Section A.2.6.5 of this Contract, the CONTRACTOR shall not pay for non-covered services as described in TennCare Division rules and regulations.

24. Section A.2.11.4 shall be deleted and replaced as follows:

A.2.11.4 Medication Assisted Treatment (MAT) Network

2.11.4.1 Buprenorphine Treatment

2.11.4.1.1 The CONTRACTOR shall establish a provider network for Medication Assisted Treatment (MAT) for members with opioid use disorder (OUD). The CONTRACTOR shall engage all contracted MAT providers, at the individual NPI level, as described below.

2.11.4.1.1.1 For the first two (2) calendar years of a provider's participation in the MAT network, the CONTRACTOR shall provide at minimum three (3) engagements as described below with the contracted MAT provider. These three (3) engagements shall include, at a minimum, the in-person check in, the in-person audit meeting, and the virtual education session as described below.

2.11.4.1.1.1.1 The CONTRACTOR shall conduct at minimum one (1) in-person check-in, at individual NPI-level, with each contracted MAT provider per calendar year. The CONTRACTOR must have the appropriate representative present to discuss the following with the provider in-person:

Amendment 11 (cont.)

- 2.11.4.1.1.1.1.1 Billing or processing questions;
- 2.11.4.1.1.1.1.2 Provide education (programmatic and clinical);
- 2.11.4.1.1.1.1.3 Quality metrics;
- 2.11.4.1.1.1.1.4 Program description and opportunities for additional supports.
- 2.11.4.1.1.1.2 The CONTRACTOR shall conduct one (1) in-person audit meeting, at individual NPI-level, per calendar year for each contracted MAT provider. The CONTRACTOR shall use the audit tool template as prescribed by TENNCARE to ensure that the providers are accurately and consistently implementing the program description and providing high-quality care. The CONTRACTOR shall review a minimum of ten (10) member charts per provider. If the provider has less than ten (10) members, the CONTRACTOR shall review all members treated with buprenorphine Medication Assisted Treatment (MAT) by that provider.
- 2.11.4.1.1.1.2.1 The CONTRACTOR may collaborate with the other TennCare MCOs to allow a provider to only be audited by one CONTRACTOR during a calendar year. If the CONTRACTOR decides to partner with another MCO, this shall fulfill the requirements for the CONTRACTOR.
- 2.11.4.1.1.1.3 The CONTRACTOR shall conduct at minimum one (1) virtual education session for all contracted MAT providers per calendar year. The virtual education session shall be for MAT providers and staff to receive additional training, education, or necessary general updates to the MAT network requirements. The CONTRACTOR shall share all topics for the virtual education sessions with TENNCARE, at least ninety (90) days in advance of the meeting and shall receive approval by TENNCARE prior to using the virtual education session.
- 2.11.4.1.1.1.3.1 The CONTRACTOR may collaborate with other TennCare MCOs to provide a single virtual education session for providers. If the CONTRACTOR decides to partner with another MCO, this shall fulfill the requirements for the CONTRACTOR.
- 2.11.4.1.1.1.3.2 The CONTRACTOR shall record the virtual education session and make the recording available to contracted MAT providers for future viewings.
- 2.11.4.1.1.2 After two (2) calendar years of a provider participating in the MAT network, the CONTRACTOR shall provide at minimum two (2) engagements with the contracted MAT provider.
- 2.11.4.1.1.2.1 Each CONTRACTOR shall conduct one (1) in-person meeting, at individual NPI-level, per contracted MAT provider per calendar year to function as a check-in and audit.
- 2.11.4.1.1.2.2 The CONTRACTOR shall conduct one (1) virtual education session per calendar year for all contracted MAT providers.

Amendment 11 (cont.)

- 2.11.4.1.1.2.2.1 The CONTRACTOR may collaborate with other TennCare MCOs to provide a single virtual education session for providers. If the CONTRACTOR decides to partner with another MCO, this shall fulfill the requirements for the CONTRACTOR.
- 2.11.4.1.1.2.2.2 The CONTRACTOR shall record the virtual education session and make the recording available to contracted MAT providers for future viewings.
- 2.11.4.1.1.3 The CONTRACTOR shall distribute quarterly MAT Network Quality Metrics Reports to all contracted MAT providers on an NPI-level as described by TENNCARE. Reports shall be distributed in a format described by TENNCARE no later than ninety (90) calendar days following the end of each calendar year quarter unless otherwise described by TENNCARE.
- 2.11.4.2 Methadone Treatment
 - 2.11.4.2.1 The CONTRACTOR shall establish a provider network by July 1, 2020 for Methadone Medication Assisted Treatment (MAT) for members with opioid use disorder (OUD) as outlined by TENNCARE. The CONTRACTOR shall comply with all guidance set forth by the TennCare Methadone Program Description.
 - 2.11.4.2.2 The CONTRACTOR shall reimburse the Methadone Medication Assisted Treatment providers at a rate specified by TENNCARE through December 31, 2021. The CONTRACTOR shall also use the payment methodology as specified by TENNCARE.
 - 2.11.4.2.3 The CONTRACTOR shall meet with each TDMHSAS licensed Opioid Treatment Program and offer each facility a contract for Methadone Medication Assisted Treatment. If the CONTRACTOR has quality of care concerns that may prevent contracting with the Opioid Treatment Program, the CONTRACTOR shall inform TENNCARE of this finding.

25. Section A.2.11.7.6 shall be amended as follows:

- 2.11.7.6 The CONTRACTOR shall, as part of its network management responsibilities, oversee the development of its contracted provider workforce, and shall take specific and measurable actions to help ensure a qualified, competent, and sufficient workforce to consistently deliver needed services in a timely manner. Responsibilities shall include the following: collection, analysis, and reporting of data about the contracted provider workforce; sufficient operational infrastructure to lead workforce development activities; the integration of workforce management responsibilities into policies and procedures for network management and support; the development and implementation of an annual workforce development plan; working with TennCare, other MCOs and/or providers to establish Statewide WFD goals, and to collaboratively plan and implement workforce development initiatives; the recruitment and employment of CHOICES and ECF CHOICES members into the workforce when appropriate; and direct assistance, support, investments, and incentives to contracted providers in order to develop the quality, competency, and sufficiency of their workforce.

Amendment 11 (cont.)

2.11.7.6.1 The CONTRACTOR shall designate a staff member located within the State of Tennessee with experience and expertise in workforce development to oversee the CONTRACTOR's workforce development responsibilities.

2.11.7.6.2 The CONTRACTOR shall ensure that sufficient resources are available to collect, analyze and report contracted provider workforce data; develop, implement, and monitor an annual workforce development plan; lead workforce development activities; monitor, on an ongoing basis, the CONTRACTOR's policies and procedures that include workforce management responsibilities, including policies and procedures for network management and support; work with TennCare, other MCOs and/or providers to collaboratively plan and implement statewide workforce development initiatives; lead the recruitment and employment of CHOICES and ECF CHOICES members into the workforce when appropriate; provide direct assistance, support, investments and incentives to providers in order to develop the quality, competency, and sufficiency of their workforce; and monitor provider workforce development activities. Provider technical assistance may include but is not limited to the following:

2.11.7.6.2.1 Provider workforce development data collection and analysis;

2.11.7.6.2.2 Provider workforce development planning;

2.11.7.6.2.3 Talent identification and acquisition (recruitment);

2.11.7.6.2.4 Competency based training and development programs, systems and incentives;

2.11.7.6.2.5 Workforce retention and promotion strategies; and

2.11.7.6.2.6 Workplace culture and business model development.

2.11.7.6.3 Workforce Development Plan and Implementation Progress Report

The CONTRACTOR shall produce a Workforce Development (WFD) Plan in collaboration with providers, members, and their families, as well as other stakeholders, including but not limited to other CONTRACTORS, and industry, education and community groups. The WFD Plan shall describe the CONTRACTOR's goals, objectives, tasks, and timelines to develop the CONTRACTOR'S provider workforce. The initial WFD Plan shall be submitted by March 1, 2020, and shall upon approval by TENNCARE, be implemented beginning June 1, 2020. The CONTRACTOR's WFD Plan shall include the following:

2.11.7.6.3.1 Analysis of currently available workforce data, including workforce capacity (size, job types, etc.) and competency (skills and workplace support);

2.11.7.6.3.2 Forecast of anticipated workforce capacity (size, job types, etc.) and competency (skills and workplace support) needs, taking into account program and population growth;

Amendment 11 (cont.)

- 2.11.7.6.3.3 Short and long-term strategic workforce development (WFD) capacity and competency objectives (e.g. addressing network adequacy, quality, direct support and health professional shortage areas, and integrated care). These objectives shall include a focus on helping enrollees and potential employers address and work through the employment barriers created by bias and discrimination based on class, race, color, national origin, age, disability, creed, religion, sex, and other protected statuses;
- 2.11.7.6.3.4 Standardized baseline workforce metrics in order to track improvement over time;
- 2.11.7.6.3.5 Description of the actions to be taken to achieve WFD goals, including specific initiatives and timelines;
- 2.11.7.6.3.6 Description of how the implementation of the plan and its impact on WFD will be monitored and measured; and
- 2.11.7.6.3.7 Description of how stakeholders, members, families and the general public have been involved in the development and will be involved in the implementation of the WFD Plan.
- 2.11.7.6.3.8 The CONTRACTOR shall routinely monitor and evaluate the implementation and progress of all initiatives and activities specified in its WFD Plan and shall formally assess and submit a semi-annual written *WFD Implementation Progress Report* of overall progress as specified in Contract. The *WFD Implementation Progress Report* shall include (at a minimum):
 - 2.11.7.6.3.8.1 A summary of actions taken and progress being made toward the achievement of Statewide WFD goals as well as CONTRACTOR specific provider network identified WFD goals, including the current status of each initiative and each short and long-term strategic WFD capacity and competency objective;
 - 2.11.7.6.3.8.2 At least annual updates to standardized baseline workforce metrics;
 - 2.11.7.6.3.8.3 A summary of direct assistance, support, investments, and incentives to providers during the reporting period in order to develop the quality, competency, and sufficiency of their workforce;
 - 2.11.7.6.3.8.4 A summary of monitoring processes and activities by the CONTRACTOR to evaluate the implementation and progress of all initiatives and activities specified in its WFD Plan; and
 - 2.11.7.6.3.8.5 A description of how stakeholders, members, families, and the general public have been involved in in the implementation of the WFD Plan during the reporting period.
- 2.11.7.6.3.9 The CONTRACTOR shall update its WFD Plan at least annually based on progress, key learnings, and new insights regarding contracted provider WFD needs. The CONTRACTOR shall involve stakeholders, members, and families in this process.

Amendment 11 (cont.)

2.11.7.6.3.10 The CONTRACTOR may partner with other MCOs in developing one consolidated WFD Plan or alternatively may partner with other MCOs on specific WFD objectives or initiatives; however, the CONTRACTOR shall be responsible for compliance with all of the WFD requirements specified in this contract.

26. Section A.2.11.10.4 shall be amended by deleting Section A.2.11.10.4.1.10 and renumbering all remaining Sections as appropriate, including any references thereto.

27. Section A.2.11.10.5 shall be amended as follows:

2.11.10.5 CHOICES and ECF CHOICES Quality Monitoring

2.11.10.5.1 Quality monitoring of ECF CHOICES services by DIDD shall include select ECF CHOICES services as determined by TENNCARE and established in TennCare protocol and interagency agreement. Quality monitoring of CHOICES services shall include only CLS and CLS-FM.

2.11.10.5.2 Upon the first initiation of services by a CHOICES CLS or CLS-FM or ECF CHOICES provider to one or more CHOICES or ECF CHOICES members (i.e., the first time the provider begins delivering services in the program), the CONTRACTOR shall notify DIDD of service initiation within ten (10) business days of the initiation of services for purposes of scheduling consultative quality monitoring surveys, as applicable, with DIDD. The data transfer process shall be developed with and approved by TENNCARE and DIDD. Upon completion of consultative surveys, the providers shall be placed on the annual survey schedule.

2.11.10.5.3 Following each consultative and annual survey involving the CONTRACTOR's members, the CONTRACTOR and DIDD shall meet to discuss the survey results and findings prior to presenting the results and finding to the provider surveyed. The CONTRACTOR shall attend the exit survey, where in DIDD explains the results of the survey with the provider. The CONTRACTOR shall be responsible for appropriate actions based on final survey results for consultative and annual surveys conducted by DIDD and follow-up visits conducted by DIDD, which may include as appropriate and specified by TENNCARE in quality monitoring protocols: onsite monitoring pending resolution of Reportable Events requiring immediate attention, corrective action plan a moratorium on new referrals.

28. Section A.2.12.11 shall be amended by deleting and replacing Section A.2.12.11.2 and adding a new Section A.2.12.11.17 as follows:

2.12.11.2 In the event that a CHOICES or ECF CHOICES HCBS provider change is initiated for a member, require that, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's person-centered support plan, as appropriate until the member has been transitioned to a new provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR, which may exceed thirty (30) days from the date of notice to the CONTRACTOR unless the member refuses continuation of services, the member's health and welfare would be otherwise at risk by remaining with the

Amendment 11 (cont.)

current provider or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm. The CONTRACTOR shall document clearly any member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the member and/or the staff will result in services not being delivered. Prior to discontinuing service to the member or prior to Provider termination of its Provider Agreement, as applicable, the Provider shall be required to:

- 2.12.11.2.1 Provide a written notification of the planned service discontinuation to the member, his/her conservator or guardian, and his/her support coordinator, no less than thirty (30) days prior to the proposed date of service or Provider Agreement termination;
- 2.12.11.2.2 Obtain the CONTRACTOR's approval, in the form of a signed PCSP, to discontinue the service and cooperate with transition to any subsequent, authorized service provider as is necessary; and
- 2.12.11.2.3 Consult and cooperate with the CONTRACTOR in the preparation of a discharge plan for all members receiving care and service from the Provider in the event of a proposed termination of service. Also, when appropriate, as part of the discharge plan, the terminating provider shall meet, consult and cooperate with any new providers to ensure continuity of care and as smooth a transition as possible.
- 2.12.11.17 The CONTRACTOR shall require that all CHOICES and ECF CHOICES providers for whom DIDD is providing quality monitoring, as specified by TENNCARE, must cooperate with all quality monitoring processes and requirements, as described herein or in TENNCARE quality monitoring protocols.

29. Section A.2.12.19 shall be amended as follows:

- A.2.12.19 The CONTRACTOR shall require that contracted providers in CHOICES and ECF CHOICES are responsible for acquiring, developing, and deploying a sufficiently staffed and qualified workforce to capably deliver services to members in a person-centered way. Upon acceptance of an authorization for services, contracted providers shall be obligated to deliver services in accordance with the PCSP, including the amount, frequency, intensity, and duration of services specified in the PCSP, and shall be responsible for arranging back-up staff to address instances when other scheduled staff are not able to deliver services as scheduled. The Provider shall, in any and all circumstances, except member refusal of continuation of services, instances where the member's health and welfare would be otherwise at risk by remaining with the current provider, if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm, or following termination of the Agreement, continue to provide services that maintain continuity of care to the person supported in accordance with his/her PCSP until other services are arranged and provided that are of acceptable and appropriate quality. The CONTRACTOR shall document clearly any member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the member and/or the worker will result in services not being delivered.

30. Section A.2.13.1.9 shall be amended by deleting and replacing the heading paragraph A.2.13.1.9.4 and sub-paragraph A.2.13.1.9.4.1.8, adding a new Section A.2.13.1.9.8, and renumbering the remaining Section A.2.13.1.9 as appropriate, including any references thereto.

2.13.1.9.4 Implementation of aligned TennCare PCMH strategy shall include at least thirty-seven percent (37.0%) of the CONTRACTOR's TennCare population beginning January 1, 2019 and at least thirty-seven percent (37.0%) of the population beginning January 1, 2020.

2.13.1.9.4.1.8 If the CONTRACTOR fails to meet and maintain the percentage benchmarks described herein, the CONTRACTOR shall provide a contingency plan to TENNCARE within five (5) business days of TENNCARE's quarterly calculation. This contingency plan will describe efforts to meet the thirty seven percent (37.0%) benchmark which shall be achieved within thirty (30) calendar days of reported deficiency. If the thirty seven percent (37.0%) benchmark is not reached by the thirtieth (30th) calendar day, the CONTRACTOR shall submit a corrective action plan (CAP) and shall be subject to liquidated damages.

2.13.1.9.8 The CONTRACTOR shall provide training and technical assistance for PCMH, THL, and EOC as described in Section A.2.18.6 of this Contract.

31. Section A.2.13.1 shall be amended by adding a new Section A.2.13.1.11 as follows:

2.13.1.9 Effective January 1, 2021, the CONTRACTOR shall reimburse providers for services provided to CoverKids members based on a state provided CoverKids Fee Schedule.

32. Section A.2.14.2 shall be deleted and replaced as follows:

2.14.2 Prior Authorization for Physical Health and Behavioral Health Covered Services

2.14.2.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.2 Prior authorization for home health nurse, home health aide, and private duty nursing services shall comply with TennCare rules and regulations, including service definitions in TennCare Rule 1200-13-13-.01, medical necessity requirements at 1200-13-16, and specific prior authorization requirements at 1200-13-13-.04(6).

2.14.2.3 Prior authorization requests shall be processed in accordance with 42 CFR § 438.210(d) and the guidelines described in TennCare rules and regulations which include, but are not

limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. If the CONTRACTOR determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See 42 C.F.R. §438.210(d)(2)(i); 42 C.F.R. §438.404(c)(6).

2.14.2.4 The CONTRACTOR's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d). TENNCARE may request copies of the CONTRACTOR's policies and procedures to assure compliance with 42 CFR, Subpart K.

33. Section A.2.15.6.3 shall be amended as follows:

2.15.6.3 Annually, beginning in 2019, the CONTRACTOR shall report the HEDIS 2019 Technical Specifications for LTSS Measures, which shall include, at minimum, the following: (1) Long term Services and Supports Comprehensive Assessment and Update; (2) Long Term Services and Supports Comprehensive Care Plan and Update; (3) Long Term Services and Supports Shared Care Plan with Primary Care Provider; and (4) Long Term Services and Supports Re-Assessment/Care Plan Update After Inpatient Discharge. The CONTRACTOR is encouraged to participate in the NCQA learning collaborative opportunity in order to receive support in reporting the new HEDIS 2019 Technical Specifications for LTSS Measures. CHOICES Group 1 Members are excluded from the HEDIS 2019 Technical Specifications for LTSS Measures.

34. Sections A.2.15.7.3.2 and A.2.15.7.4.2 shall be deleted and replaced as follows:

2.15.5.3.2 Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of detection or notification by the CONTRACTOR's QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident.

2.15.5.4.2 The CONTRACTOR shall be responsible for reviewing and tracking all unexpected deaths, regardless of circumstances or setting. The CONTRACTOR shall submit an annual report to Quality Improvement regarding all unexpected deaths, in a manner prescribed by TENNCARE.

35. Section A.2.15.10 shall be added as follows:

2.15.10 National Core Indicators and National Core Indicators – Aging and Disability

2.15.10.1 The CONTRACTOR shall assist TENNCARE in conducting an annual quality of life survey for members enrolled in CHOICES and ECF CHOICES using the *National Core Indicators*® and *National Core Indicators – Aging and Disability*® tool and processes.

Amendment 11 (cont.)

2.15.10.2 The CONTRACTOR shall collect and report Pre-Survey and Background Information for each member in the sample (including the oversample) into the ODESA database in accordance with timeframes established by TENNCARE.

2.15.10.3 The CONTRACTOR shall review the results of each survey process by region, identify strengths and opportunities, develop and implement a specific quality improvement plan for each region to address opportunities identified in the survey in order to improve member satisfaction and quality of life, and measure progress that results from these changes in order to inform ongoing quality improvement activities.

36. Section A.2.17.4.6 shall be amended by adding a new Section A.2.17.4.6.21 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.17.4.6.21 Shall include information on the beneficiary support system, including but not limited to, help with choice counseling, filing complaints or appeals, finding the status of a complaint or appeal, and resolving related issues related to rights and responsibilities.

37. Sections A.2.17.4.1, A.2.17.5 shall be deleted and replaced as follows and Section A.2.17.6 shall be amended by adding a new Section a.2.17.6.13 as follows:

2.17.4.1 The CONTRACTOR shall develop a separate member handbook for TennCare and CoverKids based on a template provided by TENNCARE, and update them periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbooks, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.

A.2.17.5 Quarterly Member Newsletter

2.17.5.1 The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members (TennCare and CoverKids) which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 The CONTRACTOR shall include the following information in each respective newsletter:

2.17.5.2.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.2.2 The procedure on how to obtain information in alternative communication formats, such as auxiliary aids or services and how to access language assistance services (i.e., interpretation and translation services) as well as a statement that interpretation and translation services and auxiliary aids or services are free. The notice of non-discrimination and taglines as required by TENNCARE shall be set forth in TENNCARE's tagline template;

2.17.5.2.3 TennCare Kids and/or CoverKids information, including but not limited to, encouragement to obtain screenings and other preventive care services;

Amendment 11 (cont.)

- 2.17.5.2.4 One article on teen health written for teenage enrollees over the age of 12. Each quarter, the teen health article must fall into one of four required categories: medical/physical health, behavioral health, anticipatory guidance, and dental. Each category must be addressed once per calendar year;
- 2.17.5.2.5 At least one specific article targeted to CHOICES members for TennCare members;
- 2.17.5.2.6 At least one specific article targeted to ECF CHOICES members for TennCare members;
- 2.17.5.2.7 Information about appropriate prescription drug usage;
- 2.17.5.2.8 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and
- 2.17.5.2.9 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to <http://tn.gov/tenncare> and click on 'Stop TennCare Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."
- 2.17.5.3 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly general newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. The newsletter may be distributed in alternative formats chosen by the CONTRACTOR and approved by TENNCARE. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, the following proof of distribution:
 - 2.17.5.3.1 Submit a final copy, describe the method/media the CONTRACTOR used to disseminate the newsletter and documentation from the MCO's staff or outside vendor indicating the quantity and date disseminated as proof of compliance by the 30th of the month following each quarter.
- 2.17.6.11 For CHOICES members, the word "CHOICES.";
- 2.17.6.12 For ECF CHOICES members, the phrase "ECF CHOICES."; and
- 2.17.6.13 For CoverKids members, the card should be accompanied by a notice regarding cost share benefit changes as described by TENNCARE.

38. Section A.2.17.7 shall be amended by adding Section A.2.17.7.5 as follows:

- 2.17.7.5 The CONTRACTOR shall include information on the beneficiary support system in the member education materials to include but not limited to help with filing complaints or appeals, finding the status of a complaint or appeal, and resolving related issues related to rights and responsibilities.

39. The lead in paragraph of Section A.2.18.3 shall be amended as follows:

A.2.18.3 Cultural Competency

As required by 42 CFR 438.206, the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's sex. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

40. Section A.2.18.5.2.3 shall be amended as follows:

2.18.5.2.3 Description of the CHOICES and ECF CHOICES program including but not limited to who qualifies for CHOICES (including the three CHOICES groups and enrollment targets for CHOICES Groups 2 and 3) and ECF CHOICES; how to enroll in CHOICES and ECF CHOICES; long-term care services available to each CHOICES Group (including benefit limits, cost neutrality cap for members in Group 2, and the expenditure cap for members in Group 3) and ECF CHOICES Group; consumer direction of eligible CHOICES and ECF CHOICES HCBS; self-direction of health care tasks for CHOICES and ECF CHOICES; the level of care assessment and reassessment process for CHOICES and ECF CHOICES; the comprehensive assessment and reassessment processes for CHOICES and ECF CHOICES; requirement to provide services in accordance with an approved plan of care or PCSP, as applicable, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule; service authorization requirements and processes; the role of the Care Coordinator, Support Coordinator, or Intensive Support Coordination Team, as applicable; the role and responsibilities of long-term care and other providers; requirements regarding the electronic visit verification system and the provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff; how to submit clean claims; documentation requirements for CHOICES and ECF CHOICES HCBS providers; and quality monitoring processes for CHOICES and ECF CHOICES;

41. Section A.2.18.6 shall be amended by adding new Sections A.18.6.8 through A.2.18.6.13 and renumbering the remaining Sections accordingly including any references thereto.

2.18.6.8 The CONTRACTOR shall provide training and technical assistance services for primary care providers (PCPs) and behavioral health providers to assist them in participating in TennCare's Patient-Centered Medical Home (PCMH) program and TennCare's Tennessee Health Link program for members with acute behavioral health needs, respectively. The CONTRACTOR shall comply with the following general requirements:

2.18.6.8.1 Prepare practices to design, execute, and track improvements in practice management, care delivery, and care team effectiveness to achieve PCMH and Health Home goals;

2.18.6.8.2 Prepare practices to proactively coordinate activities and improve relationships with other healthcare stakeholders;

Amendment 11 (cont.)

- 2.18.6.8.3 Assist practices in monitoring and improving performance on select adult and child quality measures for PCMH. The CONTRACTOR shall assist PCMH practices in reducing avoidable utilization and decreasing unnecessary spend;
- 2.18.6.8.4 In order to effectively train practices, the CONTRACTOR shall have a working knowledge of the Care Coordination Tool (CCT) and be able to communicate about the basic functionality of the tool and how it can be used to meet practice transformation goals. The State shall supply information to the CONTRACTOR on the capabilities and uses of the CCT;
- 2.18.6.8.5 The CONTRACTOR shall train practices on how to incorporate the CCT in practice to augment transformation efforts (e.g., use of Admission, Discharge, Transfer (ADT) feeds from the hospital to expedite post-discharge follow ups);
- 2.18.6.8.6 Respond to TennCare provider inquiries regarding training and transformation and, as appropriate, notify the State about those provider concerns and issues.
- 2.18.6.9 The CONTRACTOR shall maintain qualified trainers and coaches for the PCMH and THL organizations. For PCMH organizations contracted with multiple MCOs, one MCO will be assigned as the primary coach for the practice. By October 1st, the MCOs shall submit to the State each PCMH organization's primary coach for the following program year. The MCO primary coach shall be responsible for sharing updates and information with other contracted MCOs. The primary coach role is to be in regular communication and provide updates to the other contracted MCOs and be responsible for initiating annual reviews. The CONTRACTOR's trainers and coaches shall comply with the following:
 - 2.18.6.9.1 The CONTRACTOR's training and coaching staff shall have strong knowledge of primary care transformation processes;
 - 2.18.6.9.2 The CONTRACTOR's training and coaching staff shall have strong background in behavioral health treatment, service delivery, and care coordination;
 - 2.18.6.9.3 The CONTRACTOR's training and coaching staff shall have strong knowledge of the State's PCMH and Health Home programs;
 - 2.18.6.9.4 The CONTRACTOR's training and coaching staff shall have the skills necessary to effectively train practices, and equip them with best practices and approaches to optimize their population health impact, control total cost of care, and improve the patient experience;
 - 2.18.6.9.5 The CONTRACTOR shall maintain NCQA Certified Content Experts as part of the training and coaching staff. The CONTRACTOR's training and coaching staff shall complete training as required by NCQA and sit for the CCE Exam. At a minimum, the CONTRACTOR shall have three (3) staff with the specified training and sit for the NCQA CCE exam.
- 2.18.6.10 Initial Assessment of Provider Capabilities - The CONTRACTOR shall conduct an Initial Assessment of each newly participating provider that identifies current capabilities. The Initial Assessment shall be conducted no later than three months after the newly participating

Amendment 11 (cont.)

provider begins participation in the Patient Centered Medical Home and/or Tennessee Health Link programs. The CONTRACTOR shall use a standard assessment tool approved by the State in order to complete the initial readiness assessment as well as subsequent semi-annual assessments. Consistency across the initial assessment and subsequent assessments shall allow the State to uniformly track providers' progress.

- 2.18.6.10.1 The initial assessment shall differentiate between the wide ranges of provider readiness in areas including, but not limited to:
 - 2.18.6.10.1.1 Knowledge of practice transformation and quality improvement principles;
 - 2.18.6.10.1.2 Supporting processes and workflows already in place;
 - 2.18.6.10.1.3 Staff capabilities and gaps in workforce;
 - 2.18.6.10.1.4 Already existing clinical activities (e.g., same-day appointment access, care planning, patient risk stratification) relative to future required activities;
 - 2.18.6.10.1.5 Current level of quality improvement capabilities;
 - 2.18.6.10.1.6 Supporting technical capabilities and infrastructure (e.g., EHR use and data sharing, e-prescribing);
 - 2.18.6.10.1.7 Current level of medical/behavioral integration to include referral and coordination activities;
 - 2.18.6.10.1.8 Current use of team-based care;
 - 2.18.6.10.1.9 Current methods of patient engagement;
 - 2.18.6.10.1.10 Awareness of current patient experience performance (i.e., through Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, user ratings, or patient feedback) and knowledge of techniques to improve patient satisfaction;
 - 2.18.6.10.1.11 Initial practice needs and prioritized areas of improvement; and
 - 2.18.6.10.1.12 Presence and perceived enthusiasm of practice staff for practice transformation training.
- 2.18.6.10.2 The Initial Assessment shall support the CONTRACTOR in tailoring a curriculum for each practice.
- 2.18.6.10.3 The completed Initial Assessment shall be shared with TennCare via the agreed upon shared platform (i.e., SharePoint or OneDrive).
- 2.18.6.11 The CONTRACTOR shall conduct an Annual Review of each PCMH and THL organization engaged in coaching. The Annual Review shall be completed at the end of each calendar year for each PCMH and THL organization to assess their progress in the program. The

Amendment 11 (cont.)

Annual Review shall be shared with TennCare via the agreed upon shared platform (i.e., SharePoint or OneDrive).

- 2.18.6.12 The CONTRACTOR shall hold large format, in-person conferences quarterly in each of Tennessee's three grand divisions (East, Middle, and West Tennessee). The CONTRACTOR shall work collaboratively with the other MCOs in planning and executing the Large Format In-person Conferences. Each MCO shall be responsible for hosting/payment for a total of three (3) conferences throughout the year. These trainings shall comply with the following requirements:
- 2.18.6.12.1 The conference sessions shall be non-duplicative material not otherwise covered in webinars;
 - 2.18.6.12.2 The conference sessions shall target audiences of PCMH, THL, and EOC;
 - 2.18.6.12.3 The CONTRACTOR shall facilitate all aspects of the large format trainings including but not limited to communicating to providers, RSVPs, facility rental, logistics, and content;
 - 2.18.6.12.4 All training sessions shall be recorded and posted on the State's website for those practices that are unable to attend;
 - 2.18.6.12.5 The CONTRACTOR shall provide the State with detailed notes on the proceedings of the trainings, including lists of attendees, discussions initiated by the audience, and frequently asked questions;
 - 2.18.6.12.6 The State shall approve the training session topics in writing prior to the training session content being developed and advertised to providers.
- 2.18.6.13 The CONTRACTOR shall conduct live, hosted webinars with live question and answer sessions on a bi-monthly basis (each MCO shall be responsible for two webinars per year) for both PCMH and Health Homes. The CONTRACTOR shall work collaboratively with the other MCOs in planning an annual schedule for webinars. The webinars shall comply with the following requirements:
- 2.18.6.13.1 The webinars shall be non-duplicative, including material not otherwise covered in large format conferences;
 - 2.18.6.13.2 The CONTRACTOR shall facilitate all aspects of the webinars including but not limited to, communicating to providers, RSVPs, hosting the webinar platform, and content;
 - 2.18.6.13.3 The CONTRACTOR shall track attendance and share the attendance data with the State;
 - 2.18.6.13.4 The content can be targeted to PCMH providers, Health Home providers, or to both PCMH and Health Home providers;
 - 2.18.6.13.5 All live webinars shall be recorded and posted on the State's website for those practices that are unable to attend, and

Amendment 11 (cont.)

2.18.6.13.6 The State shall approve the webinar topics in writing prior to the webinar content being developed and advertised to providers.

42. Section A.2.20 shall be deleted and replaced as follows. All references shall be updated accordingly.

A.2.11 FRAUD, WASTE, AND ABUSE

A.2.11.1 General

- 2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) is the state agency responsible for the investigation of provider fraud, waste and abuse in the TennCare program.
- 2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud, waste, and abuse.
- 2.20.1.3 The Division of TennCare, Managed Care Operations, Office of Program Integrity (OPI) is the State Medicaid Agency unit responsible for the prevention, detection and investigation of alleged provider fraud, waste, and abuse of the TennCare program. OPI is responsible for providing the Managed Care Program Integrity Guidelines for Fraud, Waste, and Abuse (FWA). These guidelines shall be utilized by all MCC's to implement and maintain compliance with TennCare's FWA policies and procedures.
- 2.20.1.4 The CONTRACTOR, and any subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described 42 CFR 438.608, that includes, at a minimum:
 - 2.20.1.4.1 Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract, as well as all Federal and state requirements, related to program integrity.
 - 2.20.1.4.2 A designated Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with program integrity requirements. The Compliance Officer shall report to the CEO and the Board of Directors.
 - 2.20.1.4.3 A Regulatory Compliance Committee, consisting of members of the Board of Directors, which is responsible for oversight of the CONTRACTOR's compliance program.
 - 2.20.1.4.4 A system for training and education for the Compliance Officer, directors, managers, and employees regarding the CONTRACTOR's compliance program and program integrity-related requirements.
 - 2.20.1.4.5 Effective lines of communication between the CONTRACTOR's Compliance Officer and employees.
 - 2.20.1.4.6 Enforcement of compliance program standards and program integrity-related requirements through well-publicized disciplinary guidelines.

Amendment 11 (cont.)

- 2.20.1.4.7 A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems to reduce the potential for recurrence, and ongoing compliance with program integrity-related requirements.
- 2.20.1.5 The CONTRACTOR shall have procedures in place for reporting of all overpayments identified or recovered due to potential administrative and non-administrative fraud, waste, and abuse to the State.
- 2.20.1.6 The CONTRACTOR shall establish written policies and procedures for its employees, subcontractors, providers, and agents that provide detailed information about the False Claims Act and any other federal and state laws described in section 1902(a)(68) of the Act, including whistleblower protections, administrative remedies for false claims, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs. The CONTRACTOR shall include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.
- 2.20.1.7 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.
- 2.20.1.8 The CONTRACTOR, as well as its subcontractors shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request.
- 2.20.1.9 The CONTRACTOR's providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through TENNCARE's provider registration process.
- 2.20.1.10 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. The CONTRACTOR, its subcontractors and all tax-reporting provider

Amendment 11 (cont.)

entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, the CONTRACTOR and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the CONTRACTOR dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

- 2.20.1.11 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud, waste, and abuse activities.
- 2.20.1.12 The CONTRACTOR may recoup and retain overpayments made to providers within timeframes determined by the state.
 - 2.20.1.12.1 The CONTRACTOR shall notify TennCare OPI of any non-administrative overpayments identified outside of the timeframes determined by the state, or for which recovery is prohibited under Section A.2.20.1.10. The CONTRACTOR shall take no actions to recoup the overpayments without written authorization from TennCare OPI.
 - 2.20.1.12.2 The CONTRACTOR shall report to TennCare OPI all non-administrative overpayments, both identified and recovered, on a quarterly basis.
- 2.20.1.13 The CONTRACTOR is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
 - 2.20.1.13.1 The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or
 - 2.20.1.13.2 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee or are the subject of pending Federal or State litigation or investigation,
 - 2.20.1.13.3 The prohibition described in this section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims.
 - 2.20.1.13.4 The CONTRACTOR shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by TennCare OPI.
 - 2.20.1.13.5 In the event that CONTRACTOR recoups or otherwise obtains funds in cases where overpayment recovery is prohibited, under this section or as otherwise directed by TennCare, the CONTRACTOR shall notify the Director of TennCare OPI and take action in accordance with written instructions from the Director of TennCare OPI.

Amendment 11 (cont.)

- 2.20.1.13.6 If the CONTRACTOR fails to adhere to the prohibitions and requirements of this section, the CONTRACTOR may be subject to forfeiture of the funds to the State and the imposition of liquidated damages as described in Section E.29.2.
- 2.20.1.14 The CONTRACTOR shall comply with all federal and state requirements regarding fraud, waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.
- 2.20.1.15 The CONTRACTOR shall comply with all written direction provided by TennCare OPI regarding fraud, waste, and abuse investigations, overpayments, and any other program integrity related activities and reporting.

A.2.11.2 Reporting and Investigating Suspected Fraud, Waste, and Abuse

- 2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCD and/or OIG, in investigating fraud, waste, and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract.
- 2.20.2.2 The CONTRACTOR shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21).
- 2.20.2.3 The CONTRACTOR shall notify TBI MFCD and TennCare Office of Program Integrity simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (TBI.MFCU@tn.gov; ProgramIntegrity.TennCare@tn.gov). Along with a notification, the CONTRACTOR shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TBI MFCD and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.
- 2.20.2.4 The CONTRACTOR shall report all tips, confirmed or suspected fraud, waste, and abuse to TENNCARE and the appropriate agency as follows:
 - 2.20.2.4.1 All tips (any program integrity case received within the previous two (2) weeks) shall be reported to TennCare Office of Program Integrity and TBI MFCD;
 - 2.20.2.4.2 Suspected fraud, waste, and abuse in the administration of the program shall be reported to TennCare Office of Program Integrity, TBI MFCD and/or OIG;
 - 2.20.2.4.3 All confirmed or suspected provider fraud, waste, and abuse shall immediately be reported to TBI MFCD and TennCare Office of Program Integrity; and
 - 2.20.2.4.4 All confirmed or suspected enrollee fraud, waste, and abuse shall be reported immediately to OIG.

Amendment 11 (cont.)

- 2.20.2.5 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment VI, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.
- 2.20.2.6 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud, waste, and abuse by recipients, enrollees, applicants, or providers to TENNCARE and OIG or TBI MFC, as appropriate.
- 2.20.2.7 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents related to suspected and/or confirmed provider fraud and abuse. The CONTRACTOR shall not take any of the following actions once the suspected fraud is substantiated and reported to the state without prior written approval from the State:
 - 2.20.2.7.1 Contact the subject of the investigation about any matters related to suspected and/or confirmed fraud or abuse;
 - 2.20.2.7.2 Enter into or attempt to negotiate any settlement or agreement regarding incidents of suspected and/or confirmed fraud or abuse; or
 - 2.20.2.7.3 Accept any monetary or other thing of valuable consideration offered by the subject(s) of the investigation in connection with incidents of suspected and/or confirmed fraud or abuse.
- 2.20.2.8 The CONTRACTOR shall immediately contact the TennCare Office of Program Integrity for guidance if, during the course of an audit, it is determined the provider is already under review by the State.
- 2.20.2.8.1 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
- 2.20.2.9 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- 2.20.2.10 The CONTRACTOR shall suspend payment to a provider upon notification from TennCare OPI of the determination of a credible allegation of fraud.
- 2.20.2.11 The State shall not transfer its law enforcement functions to the CONTRACTOR.

Amendment 11 (cont.)

- 2.20.2.12 The CONTRACTOR, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the TBI MFCD/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the TBI MFCD/OIG shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCD/OIG.
- 2.20.2.13 The CONTRACTOR and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section A.2.20 of this Contract.
- 2.20.2.14 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.
- 2.20.2.15 If the CONTRACTOR subjects a provider (who is not otherwise determined to be under investigation or litigation involving the State or Federal government) to pre-payment review or any review requiring the provider to submit documentation to support a claim prior to the CONTRACTOR considering it for payment, as a result of suspected fraud, waste, and/or abuse, the CONTRACTOR shall adhere to the following, within ninety (90) days of requiring such action:
- 2.20.2.15.1 Initiate a retrospective medical and coding review on the relevant claims; and
- 2.20.2.15.2 If fraud, waste or abuse is still suspected after conducting the retrospective review, submit to TennCare OPI a suspected fraud referral, including all referral components as required by TennCare OPI.
- 2.20.2.15.3 A retrospective review shall not be conducted for providers who are determined to be under investigation or litigation involving the State or Federal government or other instances as deemed appropriate by TENNCARE.
- 2.20.2.16 Except as described in Section A.2.11.10.2 of this Contract, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.
- 2.20.2.17 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall promptly report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section A.2.12.9.36).

A.2.11.3 Compliance Plan

- 2.11.3.1 The CONTRACTOR shall have a written fraud, waste, and abuse compliance plan. A paper and electronic copy of the plan shall be provided to TennCare OPI within ninety (90)

Amendment 11 (cont.)

calendar days of Contract execution and an electronic copy shall be provided annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review as requested by TennCare OPI within thirty (30) calendar days of a request.

- 2.11.3.2 The CONTRACTOR's fraud, waste, and abuse compliance plan shall:
 - 2.11.3.2.1 Require that the reporting of suspected and/or confirmed fraud, waste, and abuse be done as required by this Contract;
 - 2.11.3.2.2 Include a risk assessment of the CONTRACTOR's various fraud, waste, and abuse/program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a provider with concerns of fraud, waste, and abuse. The CONTRACTOR shall inform TENNCARE of such action and provide details of such financial action. The assessment shall also include a listing of the CONTRACTOR's top three vulnerable areas and shall outline action plans in mitigating such risks;
 - 2.11.3.2.3 Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud, waste, and abuse compliance plan;
 - 2.11.3.2.4 Outline activities proposed for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste and on identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;
 - 2.11.3.2.5 Outline unique policy and procedures, and specific instruments designed to identify, investigate, and report fraud, waste, and abuse activities under the CHOICES' program.
 - 2.11.3.2.6 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Contract; and
 - 2.11.3.2.7 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:
 - 2.11.3.2.7.1 A list of automated pre-payment claims edits;
 - 2.11.3.2.7.2 A list of automated post-payment claims edits;
 - 2.11.3.2.7.3 A list of desk audits on post-processing review of claims;
 - 2.11.3.2.7.4 A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

Amendment 11 (cont.)

- 2.11.3.2.7.5 A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
- 2.11.3.2.7.6 A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials; and
- 2.11.3.2.7.7 A list of references in provider and member material regarding fraud, waste, and abuse referrals.
- 2.11.3.2.8 Include a list of provisions for the confidential reporting of plan violations to the designated person;
- 2.11.3.2.9 Include a list of provisions for the investigation and follow-up of any suspected or confirmed fraud, waste, and abuse, even if already reported, and/or compliance plan reports;
- 2.11.3.2.10 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;
- 2.11.3.2.11 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud, waste, and abuse compliance plan violations;
- 2.11.3.2.12 Require any confirmed or suspected provider fraud, waste, and abuse under state or federal law be reported to TBI MFCDD as well as TennCare Office of Program Integrity and that enrollee fraud, waste, and abuse be reported to the OIG;
- 2.11.3.2.13 Ensure that no individual who reports MCO violations or suspected fraud, waste, and abuse is retaliated against; and
- 2.11.3.2.14 Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.
- 2.11.3.3 The CONTRACTOR shall have provisions regarding compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.
- 2.11.3.4 The CONTRACTOR shall provide a list of procedures regarding implementation of TennCare policy on disclosure and adverse action reporting.
- 2.11.3.5 The CONTRACTOR shall have provisions in its Compliance plan regarding the reporting of fraud, waste, and abuse activities as required in Section A.2.30.15, Reporting Requirements.
- 2.11.3.6 The CONTRACTOR shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, and Personal Care Service providers against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to

Amendment 11 (cont.)

TENNCARE each month. The CONTRACTOR shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure information as provided by TENNCARE.

- 2.11.3.7 The CONTRACTOR shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The CONTRACTOR shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The CONTRACTOR shall provide the State Agency with such database and a monthly report of the exclusion check.
- 2.11.3.8 The CONTRACTOR shall have provisions in its Compliance Plan regarding prompt terminations of inactive providers due to inactivity in the past twelve (12) months, unless TENNCARE provides prior approval for a provider type to remain contracted or as otherwise required by TENNCARE.
- 2.11.3.9 The CONTRACTOR shall have provisions in its Compliance Plan regarding instructions to Personal Care Service providers to maintain written policies and procedures of their business model. The policy and procedures shall include at a minimum; roles and responsibilities of key personnel, organizational chart, succession planning, ownership, background checks for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste and abuse employee training as required by Deficit Reduction Act of 2005 Section 6032.
- 2.11.3.10 The CONTRACTOR shall have provisions in its Compliance Plan to perform a coordinated audit of a sampling of Personal Care Service providers to ensure PCS providers are only audited by one Managed Care Organization. The results of the audits will be submitted annually to TennCare with the Compliance Plan.

43. Section A.2.23 shall be amended by adding a new Section A.2.23.6 and renumbering the remaining Section as appropriate, including any references thereto.

A.2.23.6 CoverKids Copayments and Out of Pocket Calculation Interface Requirements

- 2.23.6.1 The CONTRACTOR shall be capable of automatic calculation of copayment and out-of-pocket maximums and shall maintain a year to date calculation of all copayments (including medical and vision services, dental services and prescription drugs) required by CoverKids members. The amounts shall be accumulated by family units and the CONTRACTOR shall provide and explanation of benefits (EOB) to the family when the covered members of the family have incurred copayments equal to five percent (5%) of the allowable family income. This shall include a daily interface with other managed care contractors serving the CoverKids population (DBM and PBM). Each CONTRACTOR shall update and maintain a daily file, transmit and receive the updated information to and from the DBM, PBM and other MCO Contractors. Once a family has reached the five percent (5%) threshold, the CoverKids family members shall not be responsible for copays for the remainder of the calendar year and provider payments shall be adjusted accordingly.

44. Section A.2.24.3.7 shall be deleted and replaced as follows:

2.24.3.7 The CONTRACTOR shall provide TENNCARE, in a manner prescribed by TennCare, a monthly summary that includes meeting minutes from all Advisory meetings that occurred within that month, except in instances where urgent policy or operational issues are identified. In those instances, the CONTRACTOR is required to notify TennCare within twenty four (24) business hours in writing of any policy or operational concerns. The CONTRACTOR shall also provide TennCare with an agenda for advisory meetings at least one week prior to the meeting.

45. Section A.2.24.4.6 shall be deleted and replaced as follows:

2.24.4.6 Upon implementation of ECF CHOICES, the CONTRACTOR's ECF CHOICES advisory group and ECF CHOICES member-only advisory group shall meet at least quarterly, and the CONTRACTOR shall keep a written record of meetings. The CONTRACTOR shall invite advisory group and member-only advisory group members to assist in identifying topics for discussion at each meeting. The CONTRACTOR shall include in each meeting the opportunity to provide program recommendations to the CONTRACTOR and to TENNCARE and shall notify TENNCARE, in a manner prescribed by TENNCARE, within one week of any issues, concerns, or recommendations from the advisory group meetings that would affect the broader program, policy or operations.

46. Section A.2.25.9.5 shall be deleted and replaced as follows:

2.25.9.5 Ongoing monitoring of the quality of Care/Support Coordination, including comprehensive assessment and person-centered planning processes, provided to LTSS members enrolled in the CHOICES or ECF CHOICES programs to ensure that Care/Support Coordination processes are performed in a comprehensive, holistic, person-centered manner in accordance with best practices and evidence-based guidelines, and shall also include record reviews and announced/unannounced direct observation with Care/Support Coordinators. The CONTRACTOR shall, upon TENNCARE request, develop and provide to TENNCARE, and shall implement upon approval by TENNCARE an action plan for remedying any deficiencies identified in PCSP development and/or monitoring of member outcomes.

47. Section A.2.29.1.3 shall be amended by adding a new Section A.2.29.1.3.20 as follows, renumbering the remaining Section accordingly including any references thereto and amending the renumbered A.2.29.1.3.21 as follows:

2.29.1.3.20 Maintain a sufficient number of full-time staff dedicated to the TennCare program as qualified trainers and coaches for the Patient-Centered Medical Home (PCMH) and TennCare's Tennessee Health Link organizations as well as trainers for providers regarding Episodes of Care (EOC). The CONTRACTOR's trainers and coaches shall comply with the requirements described in Section A.2.18.6.

2.29.1.3.21 At least one (1) full-time investigator per operating region dedicated solely to TennCare program investigations and at least three (3) additional staff persons responsible for all fraud, waste, and abuse detection activities, including two (2) full-time certified coders,

Amendment 11 (cont.)

and at least one (1) registered nurse, for medical record reviews dedicated solely to TennCare program fraud, waste, and abuse retrospective investigations. The investigator(s) shall have full knowledge of provider investigations related to the TennCare program and will be the key staff handling day-to-day provider investigation related inquiries from TENNCARE. The Investigators are required to be actively pursuing or currently have one or more of the listed credentials/degrees:

- 2.29.1.3.21.1 Certified Fraud Examiner;
- 2.29.1.3.21.2 NHCAA certified Anti-Fraud Investigator;
- 2.29.1.3.21.3 Degree in Statistics, Criminal Justice, Finance, Healthcare Management or any other related field that supports health care fraud investigations;
- 2.29.1.3.21.4 Certified Healthcare Coder;
- 2.29.1.3.21.5 Other nationally recognized healthcare certification.

48. Sections A.2.30.4.1, A.2.30.4.2 and A.2.30.4.3 shall be deleted and replaced as follows:

- 2.30.7.1 The CONTRACTOR shall submit a semi-annual Psychiatric Hospital/RTF Readmission Report that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges). The information shall be reported separately for members age eighteen (18) and over and under eighteen (18). These reports shall be submitted to TENNCARE on April 1 and November 1 of each year.
- 2.30.7.2 The CONTRACTOR shall submit a semi-annual Post-Discharge Services Report that provides information on Post-Discharge services appointments. The minimum data elements required are identified in Attachment IX, Exhibit B. These reports shall be submitted to TENNCARE on April 1 and November 1 of each year.
- 2.30.7.3 LEFT BLANK INTENTIONALLY

49. Sections A.2.30.4.6 shall be deleted and replaced as follows including any references thereto.

- 2.30.7.6 The CONTRACTOR shall submit Payment Reform Engagement, Education and Outreach Reports as follows:
 - 2.30.7.6.1 The CONTRACTOR shall submit an annual Provider Engagement Plan detailing communication plans with the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care providers no later than December 1st of each year for review and approval by TENNCARE. The CONTRACTOR shall submit two separate

Amendment 11 (cont.)

Provider Engagement Plans, one for PCMH/THL and one for Episodes of Care. The Provider Engagement Plan shall be effective as of January 1st of the next calendar year.

- 2.30.7.6.1.1 The Provider Engagement Plans shall be written in accordance with guidance prepared by TENNCARE. This outreach plan shall outline communication efforts with providers engaged in the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care initiatives. It shall include, but is not limited to: all proposed education regarding reading and interpreting provider reports; all proposed details regarding report delivery and accessibility; a plan for (at least) quarterly leadership meetings between MCO program leads and PCMH/THL practice leadership; detailed strategy outlining the providers or quarterbacks to prioritize when conducting outreach efforts (i.e. providers who did not open reports or owe a penalty), schedule of conferences and webinars, details of the PCMH/THL CAP and Remediation Process due to poor performance.
- 2.30.7.6.1.2 For THL providers, the CONTRACTOR may meet quarterly in-person or virtually or by phone upon the providers' request. For PCMH providers who are in their first year of participation, the CONTRACTOR shall meet with the provider quarterly in-person. For PCMH providers who have participated in the initiative for at least one year, the CONTRACTOR may alter the quarterly in person meeting schedule and/or meet by phone.
- 2.30.7.6.2 The CONTRACTOR shall submit a quarterly Provider Engagement Tracker Report in accordance with guidance prepared by TENNCARE. The CONTRACTOR shall submit the Provider Engagement Tracker no later than one (1) week after each quarter in the calendar year for the Tennessee Health Link (THL), Patient Centered Medical Homes (PCMH) and Episodes of Care initiatives. There should be separate quarterly Provider Engagement Tracker for THL, PCMH and Episodes of Care that shall record all in-person visits, calls, mailings, and all other communications for THL, PCMH and Episodes of Care. Therefore, each quarter, a total of three (3) separate Provider Engagement Tracker shall be sent to TENNCARE by the CONTRACTOR. The details regarding when such outreach shall occur are described in Sections A.2.30.4.6.2.1 to A.2.30.4.6.2.3.
- 2.30.7.6.2.1 The CONTRACTOR shall alert all providers or quarterbacks to the availability of their reports through emails and/or letters. The CONTRACTOR shall supplement alerts to providers or quarterbacks with calls, in-person visit, WebEx, fax, provider Information Expos, State Medical Association Conferences, or online videos.
- 2.30.7.6.2.2 In the initial communication to providers or quarterbacks, the CONTRACTOR shall provide instructions on 1) how to access full reports, and 2) how to share or update electronic contact information. Ensuring that providers have given their most up-to-date contact information is essential for them to receive alerts about any changes to their reports or newly released reports.
- 2.30.7.6.2.3 The CONTRACTOR shall also use in-person education, newsletters, web banners, and scripted calls to share general information and updates about Episode of Care, Patient Centered Medical Home and Health Link reports.

Amendment 11 (cont.)

2.30.7.6.3 The CONTRACTOR shall submit a copy of the CONTRACTOR's Annual Review of each PCMH and THL organization engaged in coaching as described in Section A.2.18.6. The Annual Review shall be provided to TENNCARE via the agreed upon shared platform (i.e., SharePoint or OneDrive) by the date provided and agreed upon by the PCMH and THL programs.

50. Section A.2.30.4.8.5 shall be deleted and replaced as follows:

2.30.4.8.5 The CONTRACTOR shall submit an Annual PCMH Data Report including the data elements described by TENNCARE. This report shall be submitted to TENNCARE no later than June 15 of each year.

51. Section A.2.30.4.9.4 shall be deleted and replaced as follows:

2.30.4.9.4 The CONTRACTOR shall submit an Annual *Tennessee Health Link (THL) DataReport* including the data elements described by TENNCARE. This report shall be submitted to TENNCARE no later than June 15 of each year.

52. Section A.2.30.5.3 shall be amended by deleting and replacing the word "Description" with "Strategy" and A.2.30.6.5.11 shall be deleted and replaced as follows:

2.30.6.5.11 The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES Provider Compliance Report for CHOICES members regarding personal care, attendant care, and home-delivered meals, and for ECF CHOICES members regarding personal assistance and supportive home care. The report shall contain information on specified measures including but not limited to the following:

2.30.6.5.11.1 Provider name and region in which the services are provided;

2.30.6.5.11.2 Provider ID;

2.30.6.5.11.3 Total number of visits and percentage of visits that were checked in and out via the GPS tablet;

2.30.6.5.11.4 Total number of visits and percentage of visits that were checked in and out via the IVR system;

2.30.6.5.11.5 Total number of visits and percentage of visits that were checked in and out via the worker's personal device;

2.30.6.5.11.6 Total number of visits and percentage of visits that were checked in and out via manual confirmation process due to system or authorization issues;

2.30.6.5.11.7 Total number of visits and percentage of visits that were checked in and out via manual confirmation process due to worker or provider issues. For each of these visits, the report shall include specific and immediate actions taken by the CONTRACTOR to address EVV compliance, and the efficacy of these actions in improving the provider's performance during the reporting period; and

2.30.6.5.11.8 Actions taken by the CONTRACTOR with the Providers to address compliance.

53. Section 2.30.6.7 shall be amended as follows:

2.30.6.7 The CONTRACTOR shall submit a quarterly CHOICES Care Coordination Report, in a format specified by TENNCARE that includes, but is not limited to, information on care coordination staffing, enrollment and care coordination contacts, ongoing assessment, care planning and service initiation, self-directed healthcare tasks, and the CONTRACTOR's care coordination monitoring activities (See Section 2.9.6.13.1).

54. Section 2.30.6.8 shall be amended as follows:

2.30.6.8 The CONTRACTOR shall submit a quarterly ECF CHOICES Support Coordination Report, in a format specified by TENNCARE that includes, but is not limited to, information on support coordination staffing, enrollment and support coordination contacts, , ongoing assessment, supports planning and service initiation, including the number and percent of newly enrolled members for whom immediately needed and ongoing services were initiated timely (see Sections A.2.9.6.2.5.3.1, A.2.9.6.2.5.3.2, A.2.9.6.3.26.1, and A.2.9.6.3.26.2) and in each instance they were not, the reason(s) for and length of delay, and the CONTRACTOR's support coordination monitoring activities (see Section 2.9.6.13.1).

55. Amendment 10 deleted the previous Section A.2.30.6.16 and Item 3 of Amendment 10 referenced adding a new Section A.2.30.6.25. Since A.2.30.6.16 was deleted, the remaining Section should be renumbered accordingly making the Section referenced in Item 3 of Amendment 10, Section A.2.30.6.24.

56. The renumbered Sections A.2.30.6.21 through A.2.30.6.26 shall be deleted and replaced as follows:

2.30.6.21 The CONTRACTOR shall submit to TENNCARE a Semi-Annual HH/PDN Coordination Report demonstrating the CONTRACTOR's completion of requirements described in Sections A.2.9.4.1.1 through A.2.9.4.1.3 in accordance with a template described by TENNCARE.

2.30.6.22 The CONTRACTOR shall provide a Monthly HH/PDN Coordination Report to TENNCARE, as described in Section 2.9.4.1.4.4.2, for each member outlining continued engagement, assessments, transition planning discussions and activities and supporting documentation. The report shall also include clinical assessment documenting whether the patient is ventilator dependent or has a tracheostomy or other complex respiratory care needs that qualify for PDN and current skilled nursing needs.

2.30.6.23 The CONTRACTOR shall provide a *Weekly Member MCO Selection/Assignment Report* in accordance with Section A.2.9.4.1.4.5.

2.30.6.24 The CONTRACTOR shall submit to TENNCARE a Semi-Annual HH/PDN ALJ/CEA Report demonstrating the CONTRACTOR's compliance with requirements described in Section A.2.9.4.1.8.

Amendment 11 (cont.)

2.30.6.25 The CONTRACTOR shall submit to TennCare, on a monthly basis, an ECF CHOICES Group 7 Report in a manner prescribed by TennCare. Reports are due the following month using the reporting template prescribed by TennCare. Reports will include, at minimum, data on Enrollment & Service Initiation, Service Utilization, Providers, Staffing, Support Coordination, crisis events, outcomes, transitions, transition follow-ups, and re-entry into Group 7. Group 7 reports shall include outcomes information including but not limited to the number of days behavioral respite services were utilized, number of appointments missed, number of days the member remained in a community setting, and whether the member participated in paid employment, including the number of hours the member worked and the number of school days missed, as applicable.

2.30.6.26 The CONTRACTOR shall submit to TennCare, on a monthly basis, an ECF CHOICES Group 8 Report in a manner prescribed by TennCare. Reports are due the following month using the reporting template prescribed by TennCare. Reports will include, at minimum, data on Enrollment & Service Initiation, Service Utilization, Providers, Staffing, Support Coordination, crisis events, outcomes, transitions, transition follow-ups, and re-entry into Group 8. Group 8 reports shall include outcomes information including but not limited to the number of days behavioral respite services were utilized, number of appointments missed, number of days the member remained in a community setting, and whether the member participated in paid employment, including the number of hours the member worked and the number of school days missed, as applicable.

57. Section A.2.30.12.1 shall be amended by adding the word “Extension” before Y3” as follows:

2.30.12.1 The CONTRACTOR shall submit a preliminary Performance Improvement Projects Topics report that includes information specified in Section A.15.3.6. The CONTRACTOR shall list and clearly categorize and label each PIP for the upcoming year into the area that it addresses. The CONTRACTOR shall indicate the current measurement year (Baseline, Y1, Y2, Extension Y3, Extension Y4, or Extension Y5) for each PIP. The CONTRACTOR shall also include the rationale for selection of each new PIP topic. The CONTRACTOR shall submit the report annually on or before March 31.

58. Section A.2.30.12 shall be amended by adding new Section A.2.30.12.12 as follows:

2.30.12.12 CONTRACTOR shall submit in a form and format prescribed by TENNCARE a System of Support (SOS) Report regarding Behavioral Crisis Prevention, Intervention, and Stabilization Services as described in Section 2.7.2.8.4. The report shall combine data collected by the CONTRACTOR from the SOS provider, as appropriate, with data collected directly by the CONTRACTOR. The CONTRACTOR shall establish and conduct ongoing processes to validate the accuracy of all information submitted, whether collected from the provider or directly by the CONTRACTOR, and shall take prompt action as needed to address any problems with accurate reporting.

59. Section A.2.30.19 shall be amended by deleting Sections A.2.30.19.2 and A.2.30.19.3.

60. Section A.2.30 shall be amended by adding a new Section A.2.30.25 as follows:

A.2.30.25 CoverKids 5% Annual Member Cost Sharing Report

2.30.25.1 The CONTRACTOR shall submit a quarterly CoverKids 5% Annual Member Cost Sharing Report that identifies CoverKids members who may reach their 5% annual cost sharing maximum limit.

61. Section E.13 shall be amended by adding a new Section E.13.51 as follows:

E.13.51 T.C.A. §§ 4-5-202, 71-3-1103 through 1108, 71-3-1110, and the Tennessee Title XXI Children’s Health Insurance Program State Plan.

62. Section E.29.2.2.7 shall be amended by deleting and replacing Levels A.4, A.18(a), A.21 and by adding new Levels A.14(c) and A.21(b) as follows:

LEVEL	PROGRAM ISSUES	DAMAGE
A.4	Failure to comply with obligations and time frames in the delivery of TennCare Kids screens and related services	<p><u>MCO Statewide EPSDT Rate</u> as determined from CMS416 Report:</p> <ul style="list-style-type: none"> • Below 70%: \$75,000 • Between 71% - 75%: \$50,000 • Between 76% - 79%: \$25,000 <p>AND</p> <p>\$25,000 per Region for Screening Rate below 80% as determined from CMS 416 MCO Report</p> <p>\$50,000 per Region for Screening Rate below 75% as determined from CMS 416 MCO Report</p>

LEVEL	PROGRAM ISSUES	DAMAGE
A.14(c)	Failure to conduct prior authorization processes for home health or private duty nursing in accordance with service definitions in TennCare Rule 1200-13-13-01, medical necessity requirements at 1200-13-16, and specific prior authorization requirements at 1200-13-13-04(6).	The cost of home health or private duty nursing services provided plus \$500 per day, per occurrence, for each day that home health or private duty nursing services were approved and provided in a manner that does not comport with service definitions in TennCare Rule 1200-13-13-01, medical necessity requirements at 1200-13-16, and specific prior authorization requirements at 1200-13-13-04(6)

Amendment 11 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
<p>A.18(a)</p>	<p>Failure to meet the performance standards established by TENNCARE regarding missed visits for CHOICES or ECF CHOICES members (referred to herein as “specified HCBS”)</p>	<p>\$5,000 per provider per month that 11-15% of the provider’s authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act</p> <p>\$10,000 per provider per month that 16-20% of the provider’s authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act</p> <p>\$15,000 per provider per month that 21-25% of the provider’s authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act</p> <p>\$20,000 per provider per month that 26-30% of the provider’s authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act</p> <p>\$25,000 per provider per month that 31% or more of the provider’s authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act</p> <p>TENNCARE may opt, at its discretion, to apply a \$500 per occurrence assessment in lieu of the methodology described above in addition to the cost of services not provided (if missed) and the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act</p>

Amendment 11 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
<p>A.21(a)</p>	<p>Failure to develop a PCSP for a CHOICES or ECF CHOICES member that includes all of the required elements, meets PCSP quality standards specified by TennCare, and which has been reviewed with and signed and dated by the member or his/her representative, unless the member/representative refuses to sign which shall be documented in writing</p>	<p>\$500 per deficient PCSP</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract</p>
<p>A.21(b)</p>	<p>Failure to develop and implement on a consistent and ongoing basis a comprehensive program for monitoring the effectiveness of its care coordination and support coordination processes, including ongoing quality reviews of an acceptable volume of PCSPs for each care/support coordinator to ensure accuracy, completeness, quality and consistency with quality standards as specified by TENNCARE; immediately remediate all individual findings identified through its monitoring process; track and trend such findings and remediation to identify systemic issues of poor performance and/or non-compliance; implement strategies to improve care coordination and support coordination processes and resolve areas of non-compliance, and measure the success of such strategies in addressing identified issues.</p>	<p>\$10,000 plus \$500 for each deficient PCSP for which individual findings were not timely remediated</p>

63. The Definition under the Opioid Use Disorder Treatment Service in Attachment I shall be amended as follows:

SERVICE	Opioid Use Disorder Treatment
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Definition

Treatments for opioid use disorder are designed and delivered across the continuum of care including but not limited to hospital, residential treatment, Intensive Outpatient Program, Office-Based Opioid Treatment, Opioid Treatment Program, primary care and peer recovery services. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. The duration of treatment should be based on the needs of the persons served. For opioid use disorder, one essential component within the continuum is Medication Assisted Treatment. Medication Assisted Treatment (MAT) for persons diagnosed with opioid-use disorder is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. The medications used to achieve treatment goals include buprenorphine, naltrexone, and methadone products approved by the Food and Drug Administration (FDA) for the use in the treatment of opioid-use disorder.

All providers treating members with opioid use disorder must either provide Medication Assisted Treatment (MAT) or have a policy for referral to a MAT provider for those members wishing to access MAT. Providers must also maintain compliance with the licensure rules and/or program standards set by TDMHSAS to render MAT Services.

64. Attachment II shall be amended by adding the following to the end of the existing language:

COVERKIDS COST SHARING SCHEDULE

MEDICAL BENEFITS	Copay When Household Income is Less than 200% FPL	Copay When Household Income is Between 200% FPL and 250% FPL
Chiropractic care	\$5 per visit	\$15 per visit
Emergency room	\$10 copay per use for non-emergency	\$50 copay per use for non-emergency
Hospital admissions and other inpatient services	\$5 per admission (waived if readmitted within 48 hours for same episode)	\$100 per admission (waived if readmitted within 48 hours for same episode)
Inpatient mental health and substance abuse treatment	\$5 per admission (waived if readmitted within 48 hours for same episode)	\$100 per admission (waived if readmitted within 48 hours for same episode)
Outpatient mental health and substance abuse treatment	\$5 per session	\$15 per session
Physical, speech, and occupational therapy	\$5 per visit	\$15 per visit
Physician office visit	\$5 per visit (primary care); \$5 per visit (specialist)	\$15 per visit (primary care); \$20 per visit (specialist)
Prescription drugs	\$1 generic; \$3 preferred brand; \$5 non-preferred brand	\$5 generic; \$20 preferred brand; \$40 non-preferred brand

Vision services	\$5 for lenses; \$5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	\$15 for lenses; \$15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
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65. Availability of OUD Treatment Care in Attachment IV shall be amended as follows:

1. Availability of OUD Treatment Care

The CONTRACTOR shall provide adequate numbers of OUD treatment providers for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of OUD treatment providers with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

2. Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
OUD Treatment provider contracted to treat with buprenorphine	10,000
OUD Treatment provider contracted to treat with Methadone	50,000

- 66. Attachment VII shall be amended by deleting the “TennCare Kids Screening” Performance Measure as this measure is addressed in Section E.29.2.2.7.**
- 67. Performance Measures “Length of time between psychiatric hospital/RTF discharge and first subsequent mental health service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B”, “Seven (7) day readmission rate” and “Thirty (30) day readmission rate” in Attachment VII shall each be amended by deleting the word “Quarterly” under Measurement Frequency and replacing it with “Semi-Annually”.**
- 68. Attachment VIII, Deliverable Requirements shall be amended to reflect the changes to reporting names and numbering revised by this Amendment.**

69. Attachment IX, Exhibit A shall be amended by deleting “2. Data Analysis” and “3. Action plan/follow-up”.

**ATTACHMENT IX, EXHIBIT A
PSYCHIATRIC HOSPITAL/RTF READMISSION REPORT**

The *Psychiatric Hospital/RTF Readmission Report* required in Section A.2.30.4.1 shall include, at a minimum, the following data elements:

1. Readmission rates by age group (under 18 and 18 and over) for
 - a.) Seven (7) days
 - b.) Thirty (30) days

70. Item 2.B.5) of Attachment IX, Exhibit B shall be deleted and replaced as follows:

**ATTACHMENT IX, EXHIBIT B
POST-DISCHARGE SERVICES REPORT**

The *Post-Discharge Services Report* required in Section A.2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for kept appointments that occur within seven (7) calendar days of the date of discharge from psychiatric inpatient or residential treatment facility. Appointments that meet compliance include the following:
 - A. Intake
 - B. Non Urgent Services:
 - 1) MD Services (Medication Management, Psychiatric Evaluation)
 - 2) Non MD Services (Psycho- Therapy)
 - 3) Substance Abuse (SA) (SA IOP, SA therapy)
 - 4) Psychosocial Rehabilitation (Psych Rehab, Supportive Employment, Supported Housing, Illness Management and Recovery, Peer Recovery Services and Family Support Services)
 - 5) Tennessee Health Link
 - C. Urgent Services:
 - 1) MD Services
 - 2) Non MD Services
 - 3) Substance Abuse (SA IOP) or Detoxification

71. The template contained in Attachment IX, Exhibit G shall be deleted and replaced as follows:

**ATTACHMENT IX, EXHIBIT G
MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT
PHONE LINE REPORT**

MCO Name: _____

Report Submission Date: _____

Reporting Quarter: _____

		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Call Received			
	% of Call Abandoned			
	Average Time to Answer			
	Number of Calls Answered within 30 Seconds			
	% of Call Answered within 30 Seconds			
Nurse Triage Line	Total Number of Call Received			
	% of Call Abandoned			
	Average Time to Answer			
	Number of Calls Answered within 30 Seconds			
	% of Call Answered within 30 Seconds			
Provider Services Line	Total Number of Call Received			
	% of Call Abandoned			
	Average Time to Answer			
	Number of Calls Answered within 30 Seconds			
	% of Call Answered within 30 Seconds			
Utilization Management Line	Total Number of Call Received			
	% of Call Abandoned			
	Average Time to Answer			
	Number of Calls Answered within 30 Seconds			
	% of Call Answered within 30 Seconds			

Narrative: [Explain performance deficiencies when identified and list action steps being taken] _____

Submit only Statewide data

Amendment 11 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2020.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

AMERIGROUP, TENNESSEE, INC.

BY: _____
Stuart C. McWhorter
Commissioner

BY: _____
Robert Garnett
President

DATE: _____

DATE: _____

Supplemental Documentation Required for
Fiscal Review Committee

*Contact Name:	Matt Brimm	*Contact Phone:	615-687-5811			
*Presenter's name(s):	William Aaron					
Edison Contract Number: <i>(if applicable)</i>	40180	RFS Number: <i>(if applicable)</i>	31865-00372			
*Original or Proposed Contract Begin Date:	January 1, 2014	*Current or Proposed End Date:	December 31, 2020			
Current Request Amendment Number: <i>(if applicable)</i>	11					
Proposed Amendment Effective Date: <i>(if applicable)</i>	January 1, 2020					
*Department Submitting:	Department of Finance and Administration					
*Division:	Division of TennCare					
*Date Submitted:	October 30, 2019					
*Submitted Within Sixty (60) days:	Yes					
<i>If not, explain:</i>	N/A					
*Contract Vendor Name:	AMERIGROUP Tennessee, Inc.					
*Current or Proposed Maximum Liability:	\$11,815,423,650.00					
*Estimated Total Spend for Commodities:	N/A					
*Current or Proposed Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Fully Executed Contract Summary Sheet)</i>						
FY: 2014	FY: 2015	FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY: 2020
0.00	\$927,757,750	\$1,887,665,900	\$2,000,000,000	\$2,000,000,000	\$2,000,000,000	\$2,000,000,000
FY: 2021	FY: 2022					
\$1,000,000,000						
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from Edison)</i>						
FY: 2014	FY: 2015	FY: 2016	FY: 2017	FY: 2018	FY: 2019	
0.00	\$654,157,439.34	\$1,719,763,765.88	\$1,759,964,650.17	\$1,915,278,184.66	\$2,058,086,510.86	
FY: 2020						
\$195,560,012.71 (Expenditures through July 31, 2019)						
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:			N/A			
IF surplus funds have been carried			This contract payment methodology is based			

Supplemental Documentation Required for
Fiscal Review Committee

<p>forward, please give the reasons and provide the authority for the carry forward provision:</p>	<p>on rates submitted in a competitive cost proposal fixed rates in addition to projected percentage payments. The maximum liability is calculated by Fiscal Year to include the. All unused funds for a Fiscal Year roll forward for availability throughout the term of the contract.</p>		
<p>IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:</p>	<p>TennCare is obligated by contract to reimburse the Managed Care Organization for medical claims paid by the plan to providers and pay an administrative capitation payment per member to cover administrative costs. The maximum liability amounts for this contract represent the payments made by the State to the plan to provide claims processing and other administrative services for each fiscal year. The contract payments reported for each fiscal year represent both the medical claims reimbursement payments and the administrative payments to the plan.</p>		
*Contract Funding Source/Amount:			
State:	\$4,081,019,820.00	Federal:	\$7,734,403,830.00
<i>Interdepartmental:</i>		<i>Other:</i>	
If “ <i>other</i> ” please define:		N/A	
If “ <i>interdepartmental</i> ” please define:		N/A	
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>	Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>		
Amendment #1 - December, 2014	Language modifications		
Amendment #2 – July, 2015	Language modifications		
Amendment #3 – January, 2016	Language modifications and program updates		
Amendment #4 – July 1, 2016	Language modifications		
Amendment #5 – January 2017	Language modifications and program updates; term extension and funding		
Amendment #6- July 1, 2017	Language modifications and program updates; term extension and funding		
Amendment #7 – January 1, 2018	Language modifications and program updates		
Amendment #8 – July 1, 2018	Language modifications and program updates; term extension and funding		
Amendment #9 – January 1, 2019	Language modifications and program updates		

Supplemental Documentation Required for
Fiscal Review Committee

Amendment #10 – July 1, 2019	Language modifications and program updates; term extension and funding
Method of Original Award: <i>(if applicable)</i>	RFP
*What were the projected costs of the service for the entire term of the contract prior to contract award? How was this cost determined?	\$3,775,331,800.00 Cost Proposal
*List number of other potential vendors who could provide this good or service; efforts to identify other competitive procurement alternatives; and the reason(s) a sole-source contract is in the best interest of the State.	An RFP was released and there were seven (7) proposals submitted. This contract is one of three (3) competitively procured contracts awarded to provide behavioral and medical services to TennCare enrollees statewide.
*Provide information on the circumstances and status of any disciplinary action taken or pending against the vendor during the past 5 years with state agencies/ departments, professional organizations, or through any legal action.	No disciplinary actions identified.
*In addition, please provide any information regarding the due diligence that the Department has taken to ensure that the vendor is not or has not been involved in any circumstances related to illegal activity, including but not limited to fraud.	TennCare conducted online research on the contractor and did not identify any illegal activity. Language in the contract requires immediate notification to the state regarding illegal activity or fraud if discovered during the term of this Contract.

**CONTRACT EXPENDITURES BY FISCAL YEAR
(Payment Detail Attached)**

FY 2015	\$654,157,439.34	
FY 2016	\$1,719,763,765.88	
FY 2017	\$1,759,964,650.17	
FY 2018	\$1,915,278,184.66	
FY 2019	\$2,058,086,510.86	
FY 2020	<u>\$195,560,012.71</u>	(Expenditures through July 31, 2019)
TOTAL	<u><u>\$8,302,810,563.62</u></u>	

*Liquidated Damages Total \$738,500.00 and can be found at the end of this document.

AMERIGROUP Tennessee, Inc.
Edison Contract ID: 40180

FY 2015

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01067202	0000011035	\$61,663,042.83	2/6/2015
31865	01067203	0000011035	\$36,367,920.53	2/6/2015
31865	01067204	0000011035	\$32,314,102.55	2/6/2015
31865	01084428	0000011035	\$60,717,804.02	3/6/2015
31865	01084429	0000011035	\$34,263,697.01	3/6/2015
31865	01084430	0000011035	\$30,557,637.37	3/6/2015
			\$255,884,204.31	

31865	01100224	0000011035	\$56,410,657.17	4/3/2015
31865	01100225	0000011035	\$40,602,133.57	4/3/2015
31865	01100226	0000011035	\$36,863,173.32	4/3/2015
31865	01104249	0000011035	\$109,541.00	4/10/2015
31865	01115522	0000011035	\$49,692,874.12	5/1/2015
31865	01115523	0000011035	\$40,123,732.90	5/1/2015
31865	01115524	0000011035	\$35,932,388.19	5/1/2015
31865	01134703	0000011035	\$57,692,440.11	6/5/2015
31865	01134704	0000011035	\$42,872,823.90	6/5/2015
31865	01134705	0000011035	\$37,973,470.75	6/5/2015
			\$398,273,235.03	

FY 2015 TOTAL

\$654,157,439.34

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2016

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01149293	0000011035	\$57,480,921.70	7/7/2015
31865	01149294	0000011035	\$42,155,784.48	7/7/2015
31865	01149295	0000011035	\$38,003,463.57	7/7/2015
31865	01169753	0000011035	\$57,504,000.86	8/7/2015
31865	01169754	0000011035	\$44,141,104.00	8/7/2015
31865	01169755	0000011035	\$39,722,330.20	8/7/2015
31865	01185484	0000011035	\$57,475,512.08	9/4/2015
31865	01185485	0000011035	\$43,935,938.56	9/4/2015
31865	01185486	0000011035	\$41,148,091.70	9/4/2015
			\$421,567,147.15	

31865	01200516	0000011035	\$57,305,773.29	10/2/2015
31865	01200517	0000011035	\$44,153,229.00	10/2/2015
31865	01200518	0000011035	\$40,966,392.92	10/2/2015
31865	01219354	0000011035	\$23,732,745.97	11/6/2015
31865	01219355	0000011035	\$39,083,443.90	11/6/2015
31865	01219356	0000011035	\$28,630,637.95	11/6/2015
31865	01233031	0000011035	\$53,143,146.26	12/4/2015
31865	01233032	0000011035	\$45,352,984.51	12/4/2015
31865	01233033	0000011035	\$40,851,799.62	12/4/2015
31865	01236946	0000011035	\$22,785,457.00	12/11/2015
31865	01246609	0000011035	\$55,927,646.44	12/30/2015
31865	01246610	0000011035	\$46,979,246.54	12/30/2015
31865	01246611	0000011035	\$41,500,140.55	12/30/2015
			\$540,412,643.95	

31865	01250162	0000011035	\$146,393.76	1/8/2016
31865	01265344	0000011035	\$56,284,140.58	2/5/2016
31865	01265345	0000011035	\$48,448,472.46	2/5/2016
31865	01265346	0000011035	\$42,180,522.80	2/5/2016
31865	01282838	0000011035	\$57,066,011.66	3/4/2016
31865	01282839	0000011035	\$50,785,811.58	3/4/2016
31865	01282840	0000011035	\$43,079,826.02	3/4/2016
			\$297,991,178.86	

AMERIGROUP FY 2016 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01299623	0000011035	\$57,557,954.04	4/1/2016
31865	01299624	0000011035	\$52,169,946.14	4/1/2016
31865	01299625	0000011035	\$43,201,573.64	4/1/2016
31865	01319387	0000011035	\$58,239,887.45	5/6/2016
31865	01319388	0000011035	\$53,079,943.48	5/6/2016
31865	01319389	0000011035	\$43,613,249.58	5/6/2016
31865	01335610	0000011035	\$56,153,867.57	6/7/2016
31865	01335611	0000011035	\$52,906,402.82	6/7/2016
31865	01335612	0000011035	\$42,869,971.20	6/7/2016
			\$459,792,795.92	

FY 2016 TOTAL

\$1,719,763,765.88

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2017

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01355104	0000011035	\$58,611,982.02	7/7/2016
31865	01355105	0000011035	\$54,310,790.12	7/7/2016
31865	01355106	0000011035	\$43,829,276.96	7/7/2016
31865	01369953	0000011035	\$56,988,266.33	8/5/2016
31865	01369954	0000011035	\$53,807,308.59	8/5/2016
31865	01369955	0000011035	\$43,186,711.75	8/5/2016
31865	01385624	0000011035	\$57,402,239.64	9/2/2016
31865	01385625	0000011035	\$53,441,391.91	9/2/2016
31865	01385626	0000011035	\$43,921,958.71	9/2/2016
31865	01400986	0000011035	\$940,904.29	9/30/2016
31865	01400987	0000011035	\$1,334,309.11	9/30/2016
31865	01400988	0000011035	\$1,096,633.16	9/30/2016
			\$468,871,772.59	

31865	01404488	0000011035	\$55,859,657.52	10/3/2016
31865	01404489	0000011035	\$50,719,934.66	10/3/2016
31865	01404490	0000011035	\$42,006,550.73	10/3/2016
31865	01408687	0000011035	\$550,000.00	10/14/2016
31865	01415984	0000011035	\$60,567.57	10/28/2016
31865	01419849	0000011035	\$57,924,261.02	11/4/2016
31865	01419850	0000011035	\$51,669,292.84	11/4/2016
31865	01419851	0000011035	\$42,442,997.09	11/4/2016
31865	01433397	0000011035	\$57,956,914.90	12/2/2016
31865	01433398	0000011035	\$51,060,476.59	12/2/2016
31865	01433399	0000011035	\$42,043,021.35	12/2/2016
31865	01441186	0000011035	\$9,737,964.90	12/16/2016
31865	01441187	0000011035	\$14,532,907.78	12/16/2016
31865	01441188	0000011035	\$10,986,060.32	12/16/2016
31865	01448061	0000011035	\$430,000.00	12/27/2016
31865	01448064	0000011035	\$430,414.76	12/27/2016
31865	01448067	0000011035	\$430,000.00	12/27/2016
31865	01448068	0000011035	\$433,279.60	12/27/2016
31865	01448069	0000011035	\$432,012.02	12/27/2016
			\$489,706,313.65	

AMERIGROUP FY 2017 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01451693	0000011035	\$55,842,164.62	1/6/2017
31865	01451694	0000011035	\$49,602,054.67	1/6/2017
31865	01451695	0000011035	\$40,402,976.28	1/6/2017
31865	01466551	0000011035	\$53,225,044.00	2/3/2017
31865	01466552	0000011035	\$50,608,783.31	2/3/2017
31865	01466553	0000011035	\$42,741,450.43	2/3/2017
31865	01470752	0000011035	\$572,773.19	2/13/2017
31865	01484001	0000011035	\$20,069,026.02	3/2/2017
31865	01484002	0000011035	\$40,283,987.22	3/2/2017
31865	01484003	0000011035	\$34,583,015.18	3/2/2017
31865	01500308	0000011035	\$490,311.69	3/27/2017
			\$388,421,586.61	

31865	01505022	0000011035	\$51,782,846.06	4/7/2017
31865	01505023	0000011035	\$48,393,703.92	4/7/2017
31865	01505024	0000011035	\$40,312,949.68	4/7/2017
31865	01520706	0000011035	\$51,561,793.74	5/5/2017
31865	01520707	0000011035	\$47,625,672.12	5/5/2017
31865	01520708	0000011035	\$39,850,737.68	5/5/2017
31865	01536231	0000011035	\$52,276,747.10	6/2/2017
31865	01536232	0000011035	\$45,010,226.12	6/2/2017
31865	01536233	0000011035	\$35,624,891.20	6/2/2017
31865	01539575	0000011035	\$525,409.70	6/9/2017
			\$412,964,977.32	

FY 2017 TOTAL

\$1,759,964,650.17

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2018

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01554931	0000011035	\$48,644,766.00	7/7/2017
31865	01554932	0000011035	\$41,723,938.23	7/7/2017
31865	01554933	0000011035	\$34,264,769.48	7/7/2017
31865	01569582	0000011035	\$52,845,739.73	8/4/2017
31865	01569583	0000011035	\$45,761,805.89	8/4/2017
31865	01569584	0000011035	\$37,204,619.58	8/4/2017
31865	01576478	0000011035	\$567,158.70	8/16/2017
31865	01576480	0000011035	\$565,122.47	8/16/2017
31865	01576525	0000011035	\$646,635.49	8/18/2017
31865	01576527	0000011035	\$695,021.54	8/18/2017
31865	01584404	0000011035	\$53,339,619.42	9/1/2017
31865	01584405	0000011035	\$45,933,061.82	9/1/2017
31865	01584406	0000011035	\$38,140,655.45	9/1/2017
31865	01591440	0000011035	\$923,685.79	9/15/2017
31865	01594455	0000011035	\$701,592.55	9/18/2017
31865	01594963	0000011035	\$9,501.00	9/22/2017
			\$401,967,693.14	

31865	01601746	0000011035	\$1,520,830.67	10/4/2017
31865	01601747	0000011035	\$2,185,142.26	10/4/2017
31865	01601749	0000011035	\$1,010,308.21	10/4/2017
31865	01602129	0000011035	\$45,676,748.92	10/6/2017
31865	01602128	0000011035	\$53,646,430.02	10/6/2017
31865	01602130	0000011035	\$37,651,919.21	10/6/2017
31865	01605150	0000011035	\$1,808,423.97	10/11/2017
31865	01605151	0000011035	\$2,216,890.90	10/11/2017
31865	01605152	0000011035	\$1,311,530.01	10/11/2017
31865	01608746	0000011035	\$1,430,401.22	10/18/2017
31865	01608749	0000011035	\$2,001,646.64	10/18/2017
31865	01608751	0000011035	\$1,141,911.48	10/18/2017
31865	01608787	0000011035	\$700,067.51	10/19/2017
31865	01612093	0000011035	\$1,362,742.08	10/25/2017
31865	01612096	0000011035	\$1,914,874.48	10/25/2017
31865	01612098	0000011035	\$1,021,716.10	10/25/2017
31865	01615896	0000011035	\$1,514,471.26	11/1/2017
31865	01615898	0000011035	\$1,853,679.86	11/1/2017
31865	01615899	0000011035	\$1,029,095.01	11/1/2017
31865	01616350	0000011035	\$45,683,546.49	11/3/2017
31865	01616349	0000011035	\$53,941,633.23	11/3/2017
31865	01616351	0000011035	\$37,496,343.38	11/3/2017

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01619405	0000011035	\$1,455,604.17	11/8/2017
31865	01619413	0000011035	\$2,096,355.13	11/8/2017
31865	01619421	0000011035	\$1,346,252.20	11/8/2017
31865	01623181	0000011035	\$1,728,125.66	11/15/2017
31865	01623183	0000011035	\$2,145,647.04	11/15/2017
31865	01623187	0000011035	\$1,227,454.17	11/15/2017
31865	01626809	0000011035	\$1,618,735.78	11/22/2017
31865	01626813	0000011035	\$2,015,596.45	11/22/2017
31865	01626814	0000011035	\$1,141,498.28	11/22/2017
31865	01629697	0000011035	\$901,053.34	11/30/2017
31865	01629704	0000011035	\$1,391,490.25	11/30/2017
31865	01629705	0000011035	\$2,043,183.67	11/30/2017
31865	01629707	0000011035	\$1,131,207.13	11/30/2017
31865	01630146	0000011035	\$45,770,987.41	12/1/2017
31865	01630145	0000011035	\$54,469,150.67	12/1/2017
31865	01630147	0000011035	\$38,287,172.01	12/1/2017
31865	01633650	0000011035	\$1,200,228.18	12/6/2017
31865	01633653	0000011035	\$1,745,815.22	12/6/2017
31865	01633655	0000011035	\$943,416.27	12/6/2017
31865	01637265	0000011035	\$891,209.32	12/14/2017
31865	01637248	0000011035	\$1,681,876.85	12/13/2017
31865	01637250	0000011035	\$2,387,726.88	12/13/2017
31865	01637251	0000011035	\$1,383,306.67	12/13/2017
31865	01640419	0000011035	\$1,546,911.37	12/20/2017
31865	01640421	0000011035	\$2,006,072.45	12/20/2017
31865	01640422	0000011035	\$1,213,214.23	12/20/2017
31865	01644106	0000011035	\$1,628,806.73	12/29/2017
31865	01644107	0000011035	\$2,175,325.99	12/29/2017
31865	01644108	0000011035	\$1,181,987.86	12/29/2017
			\$476,875,764.29	

31865	01647656	0000011035	\$54,159,188.58	1/5/2018
31865	01647657	0000011035	\$45,076,133.71	1/5/2018
31865	01647658	0000011035	\$37,640,818.67	1/5/2018
31865	01647296	0000011035	\$2,335,182.32	1/5/2018
31865	01647297	0000011035	\$3,161,191.52	1/5/2018
31865	01647298	0000011035	\$1,806,377.00	1/5/2018
31865	01650955	0000011035	\$1,474,483.23	1/10/2018
31865	01650956	0000011035	\$2,170,660.43	1/10/2018
31865	01650961	0000011035	\$1,236,384.54	1/10/2018
31865	01654237	0000011035	\$1,667,043.29	1/18/2018

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01654239	0000011035	\$2,238,534.80	1/18/2018
31865	01654241	0000011035	\$1,264,471.89	1/18/2018
31865	01657557	0000011035	\$1,465,659.76	1/24/2018
31865	01657559	0000011035	\$1,824,449.19	1/24/2018
31865	01657560	0000011035	\$850,250.75	1/24/2018
31865	01661085	0000011035	\$2,932,125.99	1/31/2018
31865	01661086	0000011035	\$3,896,740.98	1/31/2018
31865	01661088	0000011035	\$2,194,005.94	1/31/2018
31865	01661134	0000011035	\$898,373.04	2/1/2018
31865	01661579	0000011035	\$40,799,777.16	2/2/2018
31865	01661580	0000011035	\$32,996,941.71	2/2/2018
31865	01661581	0000011035	\$32,114,977.96	2/2/2018
31865	01665433	0000011035	\$1,661,013.90	2/7/2018
31865	01665434	0000011035	\$1,980,654.75	2/7/2018
31865	01665436	0000011035	\$1,308,903.65	2/7/2018
31865	01665484	0000011035	\$2,960,303.30	2/8/2018
31865	01665485	0000011035	\$2,451,165.54	2/8/2018
31865	01665486	0000011035	\$1,324,553.80	2/8/2018
31865	01669222	0000011035	\$1,950,306.76	2/14/2018
31865	01669223	0000011035	\$2,835,622.24	2/14/2018
31865	01669224	0000011035	\$1,468,060.37	2/14/2018
31865	01669263	0000011035	\$957,222.27	2/15/2018
31865	01673275	0000011035	\$1,625,278.14	2/22/2018
31865	01673277	0000011035	\$2,143,661.30	2/22/2018
31865	01673279	0000011035	\$1,217,924.43	2/22/2018
31865	01677254	0000011035	\$1,496,616.53	2/28/2018
31865	01677255	0000011035	\$2,130,251.79	2/28/2018
31865	01677256	0000011035	\$1,238,139.14	2/28/2018
31865	01677767	0000011035	\$89,543,116.87	3/2/2018
31865	01677768	0000011035	\$65,772,926.78	3/2/2018
31865	01677769	0000011035	\$57,721,390.28	3/2/2018
31865	01681334	0000011035	\$1,408,870.34	3/7/2018
31865	01681335	0000011035	\$1,915,307.81	3/7/2018
31865	01681337	0000011035	\$1,264,729.96	3/7/2018
31865	01681368	0000011035	\$1,046,207.41	3/9/2018
31865	01684548	0000011035	\$1,670,660.39	3/14/2018
31865	01684549	0000011035	\$2,586,412.21	3/14/2018
31865	01684550	0000011035	\$1,391,198.22	3/14/2018
31865	01688686	0000011035	\$1,480,232.67	3/21/2018
31865	01688687	0000011035	\$2,097,223.17	3/21/2018
31865	01688688	0000011035	\$1,172,342.26	3/21/2018
31865	01692615	0000011035	\$1,437,417.49	3/28/2018
31865	01692616	0000011035	\$1,998,253.77	3/28/2018

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01692617	0000011035	\$1,125,766.32	3/28/2018
			\$536,585,506.32	
31865	01696272	0000011035	\$1,331,715.97	4/4/2018
31865	01696273	0000011035	\$1,985,151.03	4/4/2018
31865	01696274	0000011035	\$1,244,960.93	4/4/2018
31865	01696644	0000011035	\$43,776,568.09	4/6/2018
31865	01696643	0000011035	\$55,798,480.50	4/6/2018
31865	01696645	0000011035	\$37,071,988.12	4/6/2018
31865	01699661	0000011035	\$1,602,894.52	4/11/2018
31865	01699662	0000011035	\$2,269,110.01	4/11/2018
31865	01699663	0000011035	\$1,292,739.88	4/11/2018
31865	01703131	0000011035	\$1,473,325.67	4/18/2018
31865	01703133	0000011035	\$2,150,754.72	4/18/2018
31865	01703134	0000011035	\$1,230,184.20	4/18/2018
31865	01703165	0000011035	\$899,599.55	4/19/2018
31865	01706653	0000011035	\$1,175,185.58	4/26/2018
31865	01706623	0000011035	\$1,435,290.74	4/26/2018
31865	01706625	0000011035	\$1,958,254.42	4/26/2018
31865	01706627	0000011035	\$1,204,832.76	4/26/2018
31865	01710493	0000011035	\$1,434,906.81	5/2/2018
31865	01710494	0000011035	\$1,851,547.84	5/2/2018
31865	01710496	0000011035	\$1,092,053.98	5/2/2018
31865	01710858	0000011035	\$42,177,524.24	5/4/2018
31865	01710857	0000011035	\$54,268,344.36	5/4/2018
31865	01710859	0000011035	\$35,716,158.86	5/4/2018
31865	01713852	0000011035	\$1,709,497.72	5/9/2018
31865	01713853	0000011035	\$2,303,743.12	5/9/2018
31865	01713854	0000011035	\$1,248,629.79	5/9/2018
31865	01717217	0000011035	\$1,599,977.93	5/16/2018
31865	01717219	0000011035	\$2,102,045.29	5/16/2018
31865	01717220	0000011035	\$1,196,988.99	5/16/2018
31865	01717605	0000011035	\$7,691,282.48	5/18/2018
31865	01717604	0000011035	\$11,331,130.78	5/18/2018
31865	01717606	0000011035	\$7,151,052.63	5/18/2018
31865	01720482	0000011035	\$1,407,523.23	5/23/2018
31865	01720483	0000011035	\$1,944,543.61	5/23/2018
31865	01720485	0000011035	\$1,179,821.67	5/23/2018
31865	01721071	0000011035	\$410,053.21	5/25/2018
31865	01721071	0000011035	\$232.39	5/25/2018
31865	01721070	0000011035	\$724,144.21	5/25/2018
31865	01721070	0000011035	\$208,405.17	5/25/2018

AMERIGROUP FY 2018 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01721072	0000011035	\$616,560.01	5/25/2018
31865	01724203	0000011035	\$1,213,616.12	5/31/2018
31865	01724211	0000011035	\$1,310,938.23	5/31/2018
31865	01724213	0000011035	\$1,713,817.14	5/31/2018
31865	01724214	0000011035	\$1,170,639.00	5/31/2018
31865	01724578	0000011035	\$43,125,542.71	6/1/2018
31865	01724577	0000011035	\$55,257,359.13	6/1/2018
31865	01724579	0000011035	\$36,023,161.90	6/1/2018
31865	01727645	0000011035	\$1,123,195.79	6/6/2018
31865	01727646	0000011035	\$1,606,383.46	6/6/2018
31865	01727647	0000011035	\$956,587.22	6/6/2018
31865	01728015	0000011035	\$629,562.00	6/8/2018
31865	01730930	0000011035	\$3,101,826.53	6/13/2018
31865	01730933	0000011035	\$4,256,365.24	6/13/2018
31865	01730935	0000011035	\$2,304,386.56	6/13/2018
31865	01733981	0000011035	\$1,408,456.81	6/20/2018
31865	01733982	0000011035	\$1,962,628.15	6/20/2018
31865	01733983	0000011035	\$1,281,642.08	6/20/2018
31865	01737531	0000011035	\$1,398,079.90	6/27/2018
31865	01737532	0000011035	\$1,768,704.78	6/27/2018
31865	01737533	0000011035	\$969,123.15	6/27/2018
			\$499,849,220.91	

FY 2018 TOTAL

\$1,915,278,184.66

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2019

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01740990	0000011035	\$1,220,313.86	7/5/2018
31865	01740991	0000011035	\$1,669,937.72	7/5/2018
31865	01740992	0000011035	\$1,091,400.14	7/5/2018
31865	01741342	0000011035	\$40,372,209.20	7/6/2018
31865	01741341	0000011035	\$53,856,643.73	7/6/2018
31865	01741343	0000011035	\$34,381,694.64	7/6/2018
31865	01741010	0000011035	\$1,071,656.25	7/9/2018
31865	01744270	0000011035	\$2,475,696.39	7/11/2018
31865	01744272	0000011035	\$3,429,752.32	7/11/2018
31865	01744275	0000011035	\$2,264,286.77	7/11/2018
31865	01747415	0000011035	\$1,578,098.04	7/18/2018
31865	01747416	0000011035	\$2,162,456.11	7/18/2018
31865	01747418	0000011035	\$1,244,689.27	7/18/2018
31865	01747465	0000011035	\$935,500.04	7/20/2018
31865	01750741	0000011035	\$1,267,789.14	7/25/2018
31865	01750743	0000011035	\$1,846,589.98	7/25/2018
31865	01750744	0000011035	\$1,020,787.56	7/25/2018
31865	01753984	0000011035	1,312,257.75	8/1/2018
31865	01753985	0000011035	1,982,228.49	8/1/2018
31865	01753986	0000011035	1,022,297.96	8/1/2018
31865	01754380	0000011035	39,570,950.91	8/3/2018
31865	01754379	0000011035	52,064,130.85	8/3/2018
31865	01754381	0000011035	33,746,433.73	8/3/2018
31865	01757373	0000011035	1,494,317.10	8/8/2018
31865	01757374	0000011035	1,855,489.16	8/8/2018
31865	01757377	0000011035	1,203,442.48	8/8/2018
31865	01757729	0000011035	8,165,321.19	8/10/2018
31865	01757728	0000011035	14,704,036.46	8/10/2018
31865	01757730	0000011035	10,180,737.74	8/10/2018
31865	01760426	0000011035	1,567,283.35	8/15/2018
31865	01760427	0000011035	2,050,626.95	8/15/2018
31865	01760429	0000011035	1,176,126.02	8/15/2018
31865	01763727	0000011035	1,251,659.39	8/22/2018
31865	01763728	0000011035	1,958,877.79	8/22/2018
31865	01763729	0000011035	1,157,998.14	8/22/2018
31865	01767119	0000011035	1,389,584.85	8/29/2018
31865	01767120	0000011035	1,873,464.54	8/29/2018
31865	01767121	0000011035	999,147.72	8/29/2018
31865	01767152	0000011035	1,335,498.86	8/30/2018
31865	01770654	0000011035	1,283,072.61	9/6/2018
31865	01770655	0000011035	1,894,499.69	9/6/2018
31865	01770656	0000011035	1,163,864.70	9/6/2018
31865	01770995	0000011035	41,248,674.38	9/7/2018

AMERIGROUP FY 2019 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01770994	0000011035	54,842,500.57	9/7/2018
31865	01770996	0000011035	35,190,589.46	9/7/2018
31865	01773715	0000011035	1,528,824.01	9/12/2018
31865	01773716	0000011035	1,913,134.55	9/12/2018
31865	01773717	0000011035	1,190,635.57	9/12/2018
31865	01776907	0000011035	1,537,555.84	9/19/2018
31865	01776908	0000011035	1,988,359.47	9/19/2018
31865	01776909	0000011035	1,280,802.69	9/19/2018
31865	01776918	0000011035	1,230,675.77	9/20/2018
31865	01780164	0000011035	1,414,396.72	9/26/2018
31865	01780165	0000011035	2,032,133.36	9/26/2018
31865	01780166	0000011035	1,069,154.11	9/26/2018
			\$484,760,286.09	

31865	01783582	0000011035	1,231,114.58	10/3/2018
31865	01783585	0000011035	1,902,564.38	10/3/2018
31865	01783589	0000011035	1,008,172.83	10/3/2018
31865	01783944	0000011035	39,930,441.23	10/5/2018
31865	01783943	0000011035	52,816,647.92	10/5/2018
31865	01783945	0000011035	34,262,808.63	10/5/2018
31865	01786778	0000011035	1,493,129.25	10/10/2018
31865	01786779	0000011035	2,054,644.64	10/10/2018
31865	01786780	0000011035	1,219,418.36	10/10/2018
31865	01790052	0000011035	1,380,644.74	10/17/2018
31865	01790053	0000011035	2,047,069.13	10/17/2018
31865	01790054	0000011035	1,200,882.37	10/17/2018
31865	01793134	0000011035	2,649,294.45	10/24/2018
31865	01793135	0000011035	3,509,612.91	10/24/2018
31865	01793137	0000011035	2,106,893.10	10/24/2018
31865	01796603	0000011035	1,351,173.48	10/31/2018
31865	01796604	0000011035	1,896,150.71	10/31/2018
31865	01796605	0000011035	1,046,505.40	10/31/2018
31865	01796932	0000011035	39,757,279.36	11/2/2018
31865	01796931	0000011035	53,369,217.13	11/2/2018
31865	01796933	0000011035	34,356,510.26	11/2/2018
31865	01799648	0000011035	1,257,550.49	11/7/2018
31865	01799649	0000011035	1,833,856.94	11/7/2018
31865	01799650	0000011035	998,880.09	11/7/2018
31865	01800034	0000011035	5,319,618.02	11/9/2018
31865	01800033	0000011035	24,826,689.79	11/9/2018
31865	01800035	0000011035	2,367,284.19	11/9/2018
31865	01802993	0000011035	1,695,752.99	11/15/2018

AMERIGROUP FY 2019 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01802994	0000011035	2,392,792.53	11/15/2018
31865	01802995	0000011035	1,335,754.20	11/15/2018
31865	01805997	0000011035	1,119,785.74	11/21/2018
31865	01805989	0000011035	1,460,974.46	11/21/2018
31865	01805991	0000011035	2,022,753.90	11/21/2018
31865	01805992	0000011035	1,181,272.22	11/21/2018
31865	01809038	0000011035	1,397,286.00	11/28/2018
31865	01809040	0000011035	1,882,930.02	11/28/2018
31865	01809041	0000011035	973,629.14	11/28/2018
31865	01812395	0000011035	1,129,700.79	12/5/2018
31865	01812396	0000011035	1,626,492.58	12/5/2018
31865	01812397	0000011035	833,469.08	12/5/2018
31865	01812400	0000011035	1,533,806.55	12/6/2018
31865	01812750	0000011035	54,027,281.61	12/7/2018
31865	01812751	0000011035	41,621,630.53	12/7/2018
31865	01812752	0000011035	35,824,164.92	12/7/2018
31865	01815774	0000011035	1,762,503.03	12/12/2018
31865	01815775	0000011035	2,288,977.23	12/12/2018
31865	01815776	0000011035	1,293,536.37	12/12/2018
31865	01818529	0000011035	1,562,203.24	12/19/2018
31865	01818530	0000011035	2,128,282.51	12/19/2018
31865	01818532	0000011035	1,196,767.63	12/19/2018
31865	01821969	0000011035	1,396,035.51	12/28/2018
31865	01821968	0000011035	2,096,477.84	12/28/2018
31865	01821967	0000011035	1,139,317.61	12/28/2018
31865	01825037	0000011035	1,233,649.33	12/31/2018
			\$485,351,281.94	

31865	01825334	0000011035	48,399,843.95	1/4/2019
31865	01825333	0000011035	59,397,485.70	1/4/2019
31865	01825335	0000011035	42,610,325.93	1/4/2019
31865	01825067	0000011035	1,039,616.13	1/4/2019
31865	01825071	0000011035	1,543,861.21	1/4/2019
31865	01825074	0000011035	798,848.24	1/4/2019
31865	01827931	0000011035	1,479,294.56	1/9/2019
31865	01827932	0000011035	1,901,169.54	1/9/2019
31865	01827933	0000011035	993,129.92	1/9/2019
31865	01830687	0000011035	1,729,032.19	1/16/2019
31865	01830688	0000011035	2,220,959.62	1/16/2019
31865	01830691	0000011035	1,322,641.30	1/16/2019
31865	01833601	0000011035	2,758,038.59	1/24/2019
31865	01833607	0000011035	3,821,889.55	1/24/2019

AMERIGROUP FY 2019 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01833609	0000011035	2,351,235.59	1/24/2019
31865	01837356	0000011035	1,421,812.40	1/30/2019
31865	01837359	0000011035	2,124,703.77	1/30/2019
31865	01837360	0000011035	948,105.91	1/30/2019
31865	01837795	0000011035	62,512,813.89	2/1/2019
31865	01837796	0000011035	34,661,053.59	2/1/2019
31865	01837797	0000011035	45,157,017.79	2/1/2019
31865	01841243	0000011035	1,671,011.76	2/6/2019
31865	01841244	0000011035	2,186,683.93	2/6/2019
31865	01841245	0000011035	1,306,203.29	2/6/2019
31865	01844675	0000011035	2,022,821.31	2/13/2019
31865	01844677	0000011035	2,428,046.08	2/13/2019
31865	01844679	0000011035	1,565,197.05	2/13/2019
31865	01848433	0000011035	1,994,185.32	2/21/2019
31865	01848434	0000011035	2,395,842.14	2/21/2019
31865	01848436	0000011035	1,404,156.61	2/21/2019
31865	01848602	0000011035	1,329,617.94	2/22/2019
31865	01852266	0000011035	1,524,811.24	2/27/2019
31865	01852267	0000011035	2,173,269.63	2/27/2019
31865	01852268	0000011035	1,256,924.64	2/27/2019
31865	01852658	0000011035	62,190,350.92	3/1/2019
31865	01852659	0000011035	52,017,147.30	3/1/2019
31865	01852660	0000011035	45,651,174.20	3/1/2019
31865	01856135	0000011035	1,894,502.02	3/6/2019
31865	01856137	0000011035	2,182,631.05	3/6/2019
31865	01856138	0000011035	1,299,973.68	3/6/2019
31865	01856163	0000011035	1,576,479.38	3/8/2019
31865	01859734	0000011035	2,030,723.49	3/13/2019
31865	01859736	0000011035	2,415,821.64	3/13/2019
31865	01859738	0000011035	1,601,258.76	3/13/2019
31865	01863519	0000011035	1,756,023.72	3/20/2019
31865	01863521	0000011035	2,349,509.89	3/20/2019
31865	01863522	0000011035	1,430,230.76	3/20/2019
31865	01866969	0000011035	1,633,389.02	3/27/2019
31865	01866970	0000011035	2,154,446.49	3/27/2019
31865	01866971	0000011035	1,151,237.93	3/27/2019
			\$525,786,550.56	

AMERIGROUP FY 2019 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01871014	0000011035	61,080,428.94	4/5/2019
31865	01871015	0000011035	53,520,869.69	4/5/2019
31865	01871016	0000011035	46,423,594.85	4/5/2019
31865	01873897	0000011035	1,337,918.14	4/15/2019
31865	01870674	0000011035	1,637,344.82	4/3/2019
31865	01873850	0000011035	1,666,160.22	4/10/2019
31865	01877220	0000011035	1,791,905.38	4/17/2019
31865	01880575	0000011035	1,737,358.66	4/24/2019
31865	01870675	0000011035	2,043,667.58	4/3/2019
31865	01873852	0000011035	2,156,983.45	4/10/2019
31865	01877221	0000011035	2,356,658.13	4/17/2019
31865	01880576	0000011035	2,166,590.31	4/24/2019
31865	01870676	0000011035	1,297,648.37	4/3/2019
31865	01873854	0000011035	1,283,547.70	4/10/2019
31865	01877222	0000011035	1,307,908.27	4/17/2019
31865	01880578	0000011035	1,283,378.13	4/24/2019
31865	01884564	0000011035	61,273,890.82	5/3/2019
31865	01884565	0000011035	53,549,503.32	5/3/2019
31865	01884566	0000011035	45,888,352.49	5/3/2019
31865	01884222	0000011035	1,548,028.22	5/1/2019
31865	01893981	0000011035	1,478,111.39	5/22/2019
31865	01884228	0000011035	1,739,647.81	5/1/2019
31865	01887474	0000011035	1,661,614.16	5/8/2019
31865	01890834	0000011035	1,930,391.60	5/15/2019
31865	01893987	0000011035	1,928,534.09	5/22/2019
31865	01897620	0000011035	1,629,323.15	5/30/2019
31865	01884229	0000011035	2,226,234.23	5/1/2019
31865	01887475	0000011035	2,185,314.69	5/8/2019
31865	01890835	0000011035	2,236,969.05	5/15/2019
31865	01893988	0000011035	2,379,935.69	5/22/2019
31865	01897622	0000011035	2,084,591.94	5/30/2019
31865	01884230	0000011035	1,223,727.59	5/1/2019
31865	01887476	0000011035	1,389,089.44	5/8/2019
31865	01890836	0000011035	1,510,469.38	5/15/2019
31865	01893989	0000011035	1,181,085.64	5/22/2019
31865	01897623	0000011035	1,175,264.14	5/30/2019
31865	01901162	0000011035	60,738,721.19	6/7/2019
31865	01901163	0000011035	54,909,522.87	6/7/2019
31865	01901164	0000011035	46,991,914.03	6/7/2019
31865	01906785	0000011035	1,592,487.27	6/19/2019
31865	01900799	0000011035	1,428,345.48	6/5/2019
31865	01904190	0000011035	1,893,888.39	6/12/2019
31865	01906789	0000011035	3,144,859.88	6/19/2019

AMERIGROUP FY 2019 (Continued)

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01910336	0000011035	1,796,160.89	6/26/2019
31865	01900801	0000011035	1,840,412.91	6/5/2019
31865	01904191	0000011035	2,581,621.88	6/12/2019
31865	01906790	0000011035	3,897,577.44	6/19/2019
31865	01910337	0000011035	1,908,431.24	6/26/2019
31865	01900802	0000011035	1,274,348.41	6/5/2019
31865	01904192	0000011035	1,361,836.39	6/12/2019
31865	01906791	0000011035	2,356,787.01	6/19/2019
31865	01910338	0000011035	1,159,435.51	6/26/2019
			562,188,392.27	

FY 2019 TOTAL

\$2,058,086,510.86

AMERIGROUP Tennessee, Inc. - Edison #40180

FY 2020

BU	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	01913945	0000011035	60,236,897.20	7/5/2019
31865	01913631	0000011035	1,614,035.76	7/3/2019
31865	01913946	0000011035	54,442,432.05	7/5/2019
31865	01913630	0000011035	3,375,799.89	7/3/2019
31865	01913947	0000011035	46,045,009.36	7/5/2019
31865	01913632	0000011035	2,215,192.20	7/3/2019
31865	01919800	0000011035	1,396,506.54	7/18/2019
31865	01913617	0000011035	1,699,865.95	7/5/2019
31865	01916787	0000011035	1,917,372.13	7/10/2019
31865	01919773	0000011035	1,847,507.98	7/17/2019
31865	01923233	0000011035	1,557,263.87	7/24/2019
31865	01926361	0000011035	1,950,684.24	7/31/2019
31865	01913618	0000011035	2,052,247.86	7/5/2019
31865	01916788	0000011035	2,518,824.37	7/10/2019
31865	01919774	0000011035	2,061,217.80	7/17/2019
31865	01923235	0000011035	2,110,961.05	7/24/2019
31865	01926362	0000011035	1,988,770.96	7/31/2019
31865	01913619	0000011035	1,327,843.99	7/5/2019
31865	01916789	0000011035	1,397,822.23	7/10/2019
31865	01919776	0000011035	1,260,296.99	7/17/2019
31865	01923237	0000011035	1,302,419.35	7/24/2019
31865	01926363	0000011035	1,241,040.94	7/31/2019
			195,560,012.71	

FY 2020 TOTAL

\$195,560,012.71

AmeriGroup Sanction Report

Item Id	MCC Name	OCCP Deliverable	OCCP Sanction Reason For Assessment	OCCP Sanction Assessment Start Date	OCCP Sanction Assessment End Date	Total amount of Assessment	OCCP Sanction Recoup Date
SAN_008121	AmeriGroup Statewide	(None)	Late ORR Response	2/7/2015	2/9/2015	\$ 300.00	3/20/2015
SAN_008448	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	4/1/2015	6/30/2015	\$ 5,000.00	10/23/2015
SAN_008264	AmeriGroup Statewide	(None)	Late Report	4/30/2015	4/30/2015	\$ 100.00	5/15/2015
SAN_008563	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	7/1/2015	9/30/2015	\$ 5,000.00	1/8/2016
SAN_009160	AmeriGroup Statewide	(None)	Failure to meet 80% rates. See Letter	10/1/2015	9/30/2016	\$ 50,000.00	5/5/2017
SAN_008761	AmeriGroup Statewide	A.2.30.13.1.1 - Quarterly Member Services, Provider Services and Utilization Management Phone Line Report	Failure to meet required benchmarks	1/1/2016	1/31/2016	\$ 25,000.00	6/17/2016
SAN_008810	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	1/1/2016	3/31/2016	\$ 5,000.00	7/1/2016
SAN_008870	AmeriGroup Statewide	A.2.30.13.1.1 - Quarterly Member Services, Provider Services and Utilization Management Phone Line Report	Failure to meet required benchmarks	4/1/2016	6/30/2016	\$ 550,000.00	9/30/2016
SAN_008921	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	4/1/2016	6/30/2016	\$ 5,000.00	9/30/2016
SAN_009011	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	7/1/2016	9/30/2016	\$ 5,000.00	1/6/2017
SAN_009107	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	10/1/2016	12/31/2016	\$ 5,000.00	4/7/2017
SAN_009274	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	1/1/2017	3/31/2017	\$ 5,000.00	7/7/2017

SAN_009315	AmeriGroup Statewide	A.2.17.5.1 - Quarterly Member Newsletter	Failure to comply with the mailing time frames for providing the Member Newsletter as required.	4/1/2017	6/30/2017	\$ 5,000.00	9/1/2017
SAN_009367	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	4/1/2017	6/30/2017	\$ 5,000.00	10/6/2017
SAN_009466	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	7/1/2017	9/30/2017	\$ 5,000.00	1/5/2018
SAN_009581	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	10/1/2017	12/31/2017	\$ 5,000.00	4/6/2018
SAN_009760	AmeriGroup Statewide	(None)	Failure to achieve accuracy rates - Telephone Numbers	4/1/2018	6/30/2018	\$ 5,000.00	11/2/2018
SAN_009631	AmeriGroup Statewide	(None)	Failure to provide an acceptable corrective action plan	4/5/2018	4/11/2018	\$ 3,500.00	5/4/2018
SAN_009632	AmeriGroup Statewide	A.2.30.6.24 - Weekly Member MCO Selection/Assignment Report	Late deliverable	4/19/2018	4/19/2018	\$ 100.00	5/4/2018
SAN_009945	AmeriGroup Statewide	A.2.30.13.1.1 - Quarterly Member Services, Provider Services and Utilization Management Phone Line Report	Failure to meet required benchmarks	8/1/2018	8/30/2018	\$ 25,000.00	8/2/2019
SAN_009751	AmeriGroup Statewide	(None)	Late ORR Response	8/24/2018	8/24/2018	\$ 100.00	11/2/2018
SAN_009756	AmeriGroup Statewide	A.2.30.6.22 - Semi-Annual HH/PDN Coordination Report	Late Response	9/7/2018	9/7/2018	\$ 100.00	11/2/2018
SAN_009824	AmeriGroup Statewide	(None)	Late ORR Response - 15 days late	11/21/2018	12/7/2018	\$ 1,500.00	1/4/2019
SAN_009921	AmeriGroup Statewide	(None)	Failure to meet required benchmark - January 2019 - CHOICES HCBS	1/1/2019	1/31/2019	\$ 10,000.00	5/3/2019
SAN_009922	AmeriGroup Statewide	(None)	Failure to meet required benchmark - January 2019 - ECF CHOICES HCBS	1/1/2019	1/31/2019	\$ 10,000.00	5/3/2019

SAN_009866	AmeriGroup Statewide	(None)	Late ORR Response	2/2/2019	2/12/2019	\$ 1,100.00	3/1/2019
SAN_010016	AmeriGroup Statewide	A.2.30.4.8.5 - Semi-Annual PCMH Heat Maps Performance Tracker Report	Deficient Report - A.2.30.4.8.5 - Semi-Annual PCMH Heat Maps Performance Tracker Report	7/10/2019	7/24/2019	\$ 1,500.00	9/6/2019
SAN_010052	AmeriGroup Statewide	A.2.30.4.9.6 - Quarterly Tennessee Health Link (THL) Provider Sample Report	Late Report	8/9/2019	8/12/2019	\$ 200.00	9/6/2019

TOTAL

\$ 738,500.00