



January 4, 2019

Ms. Krista Lee, Executive Director  
Fiscal Review Committee  
8<sup>th</sup> Floor, Rachel Jackson Bldg.  
Nashville, TN 37243

RE: Amerigroup Tennessee, Inc. – Amendment 9  
BlueCross BlueShield of Tennessee, Inc. – Amendment 5  
Legility Data Solutions, LLC – Amendment 6 (Name Change from Document Solutions of Nashville, Inc.)  
Navigant Consulting, Inc. – Amendment 2 (Name Change from Aon Consulting Inc.)

Dear Ms. Lee:

The Department of Finance and Administration, Division of TennCare, is submitting for consideration by the Fiscal Review Committee the following three (3) amendments and all required documentation and approvals.

1) AMERIGROUP Tennessee, Inc.:

This managed care contract is being amended to provide relative changes to the managed care program including: 1) Addition of ECF CHOICES Groups 7 & 8 (and Integrated Support Coordination Team) 2) Revisions to ECF CHOICES Expenditure Cap exceptions. 3) Revisions to CHOICES & ECF CHOICES deadline for intake processes with exceptions and related liquidated damage. 4) Added collaboration requirements for Beneficiary Support System. 5) Prohibition on reimbursement conditions that require Medicare Explanation of Benefits for Nursing Facility claims. 6) Added community provider forums to CHOICES Advisory Group requirements. 7) Medication-assisted treatment (MAT) requirements. 8) Clarify Home Health Agency requirements. 9) Updated reporting requirements for Tennessee Health Link (THL) and Patient Centered Medical Home (PCMH). 10) Population Health updates for clarity and to align with NCQA Population Health requirements. 11) Program Integrity clarifications, including updated Fraud and Abuse Reporting Forms. 12) NEMT clarifications (mileage reimbursement, member survey's, reporting, etc.). 13) Housekeeping (definitions, reporting, etc.).

2) BlueCross BlueShield of Tennessee, Inc. is for the delivery of AccessTN, and CoverKids (collectively, "Cover Tennessee") self-funded health plan services, including administrative services, provider network development and maintenance, enrollment, premium equivalent billing and collection, utilization, case and care management, disease management, medical benefits, pharmacy benefits, behavioral health benefits, customer service, claims adjudication and adjustment, appeals services, financial and program reporting for each of the programs. This contract provides delivery of CoverKids services to those 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 as well as Center for Medicare and Medicaid (CMS) required regulations,



including: Social Security requirements, HIPAA Confidentiality requirements, Civil Rights requirements, and applicable Encounter submission. The scope of work is being updated to incorporate the Population Health reporting requirements, Center for Medicare and Medicaid (CMS) required regulations and Civil Rights regulations.

- 3) Legility Data Solutions, LLC, previously known as Document Solutions of Nashville, Inc., is being brought before FRC in order to enact a name change. No other adjustments are being made at this time.
- 4) Navigant Consulting, Inc., previously known as Aon Consulting Inc., is being brought before FRC in order to enact a name change. No other adjustments are being made at this time.

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 that reads "Wendy Long, MD" followed by a stylized signature.

William Aaron  
Chief Financial Officer

cc: Wendy Long, M.D., Deputy Commissioner

## 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: [Agsprrs.Agsprsr@tn.gov](mailto:Agsprrs.Agsprsr@tn.gov)

**APPROVED**

Kevin C. Bartels for  
Michael F. Perry

Digitally signed by Kevin C. Bartels for  
Michael F. Perry  
DN: cn=Kevin C. Bartels for Michael F.  
Perry, o=CPO, ou,  
email=Kevin.C.Bartels@tn.gov, c=US  
Date: 2018.10.26 13:36:21 -05'00'

CHIEF PROCUREMENT OFFICER

DATE

<b>Agency request tracking #</b>	<b>31865-00372</b>	
<b>1. Procuring Agency</b>	<b>Department of Finance and Administration Division of TennCare</b>	
<b>2. Contractor</b>	<b>AMERIGROUP Tennessee, Inc.</b>	
<b>3. Edison contract ID #</b>	<b>40180</b>	
<b>4. Proposed amendment #</b>	<b>9</b>	
<b>5. Contract's Original Effective Date</b>	<b>January 1, 2014</b>	
<b>6. Current end date</b>	<b>December 31, 2019</b>	
<b>7. Proposed end date</b>	<b>December 31, 2019</b>	
<b>8. Current Maximum Liability or Estimated Liability</b>	<b>\$ 9,815,423,650.00</b>	
<b>9. Proposed Maximum Liability or Estimated Liability</b>	<b>\$ N/A</b>	
<b>10. Strategic Technology Solutions Pre-Approval Endorsement Request</b> <i>– information technology service (N/A to THDA)</i>	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
<b>11. eHealth Pre-Approval Endorsement Request</b> <i>– health-related professional, pharmaceutical, laboratory, or imaging</i>	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
<b>12. Human Resources Pre-Approval Endorsement Request</b> <i>– state employee training service</i>	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
<b>13. Explain why the proposed amendment is needed</b>		
<p>This competitively procured contract is being amended to provide relative changes to the managed care program including:</p> <ol style="list-style-type: none"> <li>1) Addition of ECF CHOICES Groups 7 &amp; 8 (and Integrated Support Coordination Team)</li> <li>2) Revisions to ECF CHOICES Expenditure Cap exceptions</li> <li>3) Revisions to CHOICES &amp; ECF CHOICES deadline for intake processes with exceptions and related liquidated damage</li> <li>4) Added collaboration requirements for Beneficiary Support System</li> <li>5) Prohibition on reimbursement conditions that require Medicare Explanation of Benefits for</li> </ol>		

Agency request tracking #	31865-00372
<p><b>Nursing Facility claims</b></p> <ul style="list-style-type: none"> <li>6) Added community provider forums to CHOICES Advisory Group requirements</li> <li>7) Medication-assisted treatment (MAT) requirements</li> <li>8) Clarify Home Health Agency requirements</li> <li>9) Updated reporting requirements for Tennessee Health Link (THL) and Patient Centered Medical Home (PCMH)</li> <li>10) Population Health updates for clarity and to align with NCQA Population Health requirements</li> <li>11) Program Integrity clarifications, including updated Fraud and Abuse Reporting Forms</li> <li>12) NEMT clarifications (mileage reimbursement, member survey's, reporting, etc.)</li> <li>13) Housekeeping (definitions, reporting, etc.)</li> </ul>	
<p><b>14. If the amendment involves a change in Scope, describe efforts to identify reasonable, competitive, procurement alternatives to amending the contract.</b></p> <p><b>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.</b></p>	
<p><b>Signature of Agency head or authorized designee, title of signatory, and date</b> (the authorized designee may sign his or her own name if indicated on the Signature Certification and Authorization document)</p> <p style="text-align: center;">  <span style="float: right; margin-right: 50px;">10/24/18</span> </p>	



## CONTRACT AMENDMENT COVER SHEET

<b>Agency Tracking #</b> 31865-00372	<b>Edison ID</b> 40180	<b>Contract #</b>	<b>Amendment #</b> 09
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<b>Contractor Legal Entity Name</b> AMERIGROUP Tennessee, Inc.	<b>Edison Vendor ID</b> 0000011035
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**Amendment Purpose & Effect(s)**  
Updates Scope – Statewide TennCare Managed Care

<b>Amendment Changes Contract End Date:</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<b>End Date:</b> December 31, 2019
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**TOTAL Contract Amount INCREASE or DECREASE per this Amendment** (zero if N/A): **\$ 0.00**

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	\$341,420,000.00	\$658,580,000.00			\$1,000,000,000.00
<b>TOTAL:</b>	<b>\$3,398,179,820.00</b>	<b>\$6,417,243,830.00</b>			<b>\$9,815,423,650.00</b>

<p><b>Budget Officer Confirmation:</b> 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.</p>	<p><i>CPO USE</i></p>	
<b>Speed Chart</b> (optional)	<b>Account Code</b> (optional)	

**AMENDMENT NUMBER 9  
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 following definitions shall be amended or added in Section 1 as follows:**

Aging Caregiver - An individual who is at least seventy-five (75) years old and is the custodial parent or custodial caregiver of an individual with an intellectual disability or an individual who is at least eighty (80) years old and is the custodial parent or custodial caregiver of an individual with a developmental disability (other than an intellectual disability) pursuant to T.C.A. § 33-5-112 as amended.

Beneficiary Support System – The Beneficiary Support System is an entity independent of TennCare MCOs that provides support to applicants and enrollees before and after enrollment pursuant to 42 C.F.R § 438.71. Specific to CHOICES and ECF CHOICES, the State’s Beneficiary Support System contractor will assist applicants and enrollees with navigation of the CONTRACTOR’s appeals and grievance processes upon request by applicants and enrollees.

ECF CHOICES Group (Group) – One of the five groups of TennCare enrollees who are enrolled in ECF CHOICES. All Groups in ECF CHOICES receive services in the community. These Groups are:

**Group 4**

(Essential Family Supports) - Children under age twenty one (21) with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF Care, or who, in the absence of HCBS, are “At risk of NF placement;” and adults age 21 and older with I/DD living at home with family caregivers who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are “At risk of NF placement,” and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

**Group 5**

(Essential Supports for Employment and Independent Living) - Adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are “At Risk” of nursing facility placement. To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase

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2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups. An eligible adult age 21 and older who meets NF LOC may enroll in ECF CHOICES Group 5, so long as the person's needs can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap, including individuals with I/DD who have an aging caregiver. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 5, if they meet eligibility criteria.

### **Group 6**

(Comprehensive Supports for Employment and Community Living) - Adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD who meet nursing facility level of care and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 6, if they meet eligibility criteria.

### **Group 7**

(Intensive Behavioral Family Supports) – [Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment,] children under age twenty one (21) who live at home with family caregivers and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). The child must meet the NF LOC and need and receive HCBS as an alternative to NF Care. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. This group shall be implemented by MCO based on TENNCARE's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

### **Group 8**

(Comprehensive Behavioral Supports for Employment and Community Living) – [Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment,] adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment, meet nursing facility level of care, and need and are receiving specialized services for I/DD. A person must be in one of the following target groups: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term institutional placement (including residential psychiatric treatment facility). To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 8, if they meet eligibility criteria. This group shall be implemented by MCO based on TENNCARE's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

ECF CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in ECF CHOICES Groups 4, 5, 6, 7, or 8 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare

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demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall, for members enrolled in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 or 8 who also have an expenditure cap based on the comparable cost of institutional care, be counted for purposes of determining whether an ECF CHOICES member's needs can be safely met in the community within his or her individual expenditure cap.

ECF CHOICES Consumer Directed Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in ECF CHOICES Groups 4, 5, 6, 7 or 8 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall, for members enrolled in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 or 8 who also have an expenditure cap based on the comparable cost of institutional care, be counted for purposes of determining whether an ECF CHOICES member's needs can be safely met in the community within his or her individual expenditure cap.

ECF CHOICES Referral List – The listing of Potential Applicants that have completed both a screening and intake process to determine interest in and eligibility for applying for enrollment into the ECF CHOICES program.

Eligible ECF CHOICES HCBS – Personal assistance, supportive home care, hourly respite, community transportation, and/or any other ECF CHOICES HCBS specified in TennCare rules as eligible for consumer direction which an ECF CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service. Eligible ECF CHOICES HCBS do not include home health, private duty nursing services, or Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS).

Employment and Community First (ECF) CHOICES - A managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also). Synonymous with Member. For purposes of Enrollee Benefit Appeals and the 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.

Expenditure Cap – The annual limit on expenditures for CHOICES or ECF CHOICES that a member enrolled in CHOICES Group 3 or ECF CHOICES HCBS, as applicable, can receive. For purposes of the Expenditure Cap for

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members in CHOICES Group 3 and ECF CHOICES Group 4, the cost of minor home modifications is not counted in calculating annual expenditures for CHOICES HCBS or ECF CHOICES HCBS. For purposes of the Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on the comparable cost of institutional care, the cost of home health and private duty nursing shall be counted against the member's Expenditure Cap.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES and ECF CHOICES HCBS are eligible for Consumer Direction. CHOICES and ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the member's Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on the comparable cost of institutional care.

Integrated Support Coordination Team (IST) – For purposes of ECF CHOICES Groups 7 and 8, the team consisting of the member's Support Coordinator and the Behavior Supports Director as defined in 2.29.1.3.6 or a similarly qualified behavior supports professional, who shall be responsible for performing in close collaboration the required Support Coordination functions as specified in this Contract, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning.

Interagency Review Committee – The committee composed of staff from TennCare and DIDD that reviews requests submitted on behalf of a Potential Applicant in order to determine whether the Potential Applicant meets reserve capacity criteria as defined in TennCare Rule 1200-13-01-.02 or in Operational Procedures submitted to CMS. Except for individuals with ID or DD who have an Aging Caregiver or as otherwise specified by TennCare, a determination by the Interagency Review Committee that a Potential Applicant meets reserve capacity criteria shall be required before DIDD or an MCO proceeds with an enrollment visit to determine if the Potential Applicant qualifies to enroll in ECF CHOICES in a reserve capacity slot designated for such purpose.

Ongoing ECF CHOICES HCBS – Specified ECF CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or in the case of community-based residential alternatives on a continuous basis, or which may be one component of a continuum of services intended to achieve employment. Ongoing ECF CHOICES HCBS include: Supportive Home Care, Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS), Family Caregiver Stipend in lieu of Supportive Home Care, Independent Living Skills Training, Community Integration Support Services, Personal Assistance, Community Transportation, Community Living Supports (CLS), Community Living Supports Family Model (CLS-FM), Intensive Behavioral Community Transition and Stabilization Services, Exploration, Discovery, Benefits Counseling, Situational Observation and Assessment, Job Development or Self-Employment Plan, Job Development or Self-Employment Start Up, Job Coaching (including Competitive, Integrated Employment and

Amendment 9 (cont.)

Self-Employment), Supported Employment – Small Group, Co-worker Supports, Career Advancement, and Integrated Employment Path Services (Time Limited Pre-Vocational Training).

Reserve Capacity Slot– For the purposes of ECF CHOICES, the state’s authority to reserve a finite number of program slots in a particular ECF CHOICES Group for persons in specified circumstances as defined in TennCare Rule 1200-13-01-.02 or in Operational Procedures submitted to CMS.

Self-Direction of Health Care Tasks – A decision by a CHOICES or ECF CHOICES member participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES or ECF CHOICES HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES or ECF CHOICES member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible CHOICES or ECF CHOICES HCBS s/he is authorized to receive.

Support Coordination Team – If an MCO elects to use a support coordination team, the support coordination team shall consist of a Support Coordinator and specific other persons with relevant expertise and experience who are assigned to support the Support Coordinator in the performance of support coordination activities for an ECF CHOICES member as specified in this Contract and in accordance with Section A.2.9.6, but shall not perform activities that must be performed by the Support Coordinator, including comprehensive assessment, caregiver assessment, development of the PCSP, and minimum Support Coordination contacts. In the case of ECF CHOICES Groups 7 and 8, certain Support Coordination activities shall be completed by an Integrated Support Coordination Team as defined herein.

Support Coordination Unit – A specific group of staff within the MCO’s organization dedicated to ECF CHOICES that is comprised of Support Coordinators and Support Coordinator supervisors and which may also include support coordination teams. Integrated Support Coordination Teams shall be part of the Support Coordination Unit.

Support Coordinator – The individual who has primary responsibility for performance of support coordination activities for an ECF CHOICES member as specified in the CRA and meets the qualifications specified in Section A.2.9.6 of the CRA. In the case of ECF CHOICES Groups 7 and 8, certain Support Coordination activities shall be performed by the Integrated Support Coordination Team, as defined herein.

Transition Allowance – A per member allotment not to exceed two thousand dollars (\$2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided to a CHOICES or ECF CHOICES member as a cost-effective alternative to continued institutional care for which the CONTRACTOR is responsible for payment (e.g., a nursing facility or inpatient psychiatric care at a Regional Mental Health Institute) in order to facilitate transition to the community. The allotment is only appropriate when such a member will, upon transition, will receive more cost-effective home and community based services either non-residential services or consumer directed companion care in their own home, residential services in a non-provider owned residential setting, or for limited items, as specified below in this section, in provider-owned residential settings. Provider-owned settings include settings which the provider owns, co-owns, has any ownership interest in, or has any affiliation with the entity that owns the home in which the member will reside. A Transition Allowance may also be provided as a cost-effective alternative when a member must transition out of the current living arrangement and would, but for the availability of the Transition Allowance, require placement in a medical institution for which the CONTRACTOR is responsible for payment, as stated above. The CONTRACTOR shall only be responsible for

payment of nursing facility services when the person meets nursing facility level of care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain (including community resources that the CONTRACTOR is expected to assist the member in accessing first) and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits (rental security deposits required to obtain a lease—e.g., first and last month's rent—may be covered even if not refundable; ongoing rent may not), essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. In provider-owned settings, the transition allowance shall only be used for household items and furnishings that are for the member's personal use, such as bedroom furniture, towels, linens, sheets, and other similar items as approved by TENNCARE. In provider-owned settings (as defined herein), a transition allowance shall not be used for rent or utility deposits or for household items and furnishings for common use of all persons residing in the home. Regardless of setting, items purchased as part of the Transition Allowance shall be the personal property of the member, not the provider.

**2. Section A.2.1.2.1 shall be amended as follows:**

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.

**3. Section A.2.3.2.2 shall be amended as follows:**

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.

**4. Section A.2.6.1.2 shall be amended by amending A.2.6.1.2.3 and A.2.6.1.2.5 as follows:**

2.6.1.2.3 As required in Section A.2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term services and supports and ensure collaboration among physical health, behavioral health, and long-term services and supports providers. For CHOICES members and ECF CHOICES members, the member's Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term services and supports providers.

2.6.1.2.5 The CONTRACTOR shall provide the appropriate level of Population Health services (see Section A.2.8.4 of this Contract) to non-CHOICES and non-ECF CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral health conditions. If a member with co-morbid physical and behavioral health conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section A.2.9.6.1.9 of this Contract, the CONTRACTOR shall ensure that upon enrollment into

CHOICES or ECF CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member’s assigned Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, has primary responsibility for coordination of all the member’s physical health, behavioral health and long-term services and supports needs. The member’s Care Coordinator or Support Coordinator may use resources and staff from the CONTRACTOR’s Population Health 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. The CONTRACTOR shall report on its Population Health activities per requirements in Section A.2.30.5.

**5. Section A.2.6.1.6.3 shall be amended as follows:**

2.6.1.6.3 The following long-term services and supports are available to ECF CHOICES members, per Group and subject to all applicable service definitions, benefit limits, and Expenditure Caps, when the services have been determined medically necessary by the CONTRACTOR.

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Respite (up to 30 days per calendar year <b>or</b> up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X		
Supportive home care (SHC)	X				
Family caregiver stipend in lieu of SHC (up to \$500 per month for children under age 18; up to \$1,000 per month for adults age 18 and older)	X				
Community integration support services (subject to limitations specified in the approved 1115 waiver and TennCare Rule)	X	X	X	X	
Community transportation	X	X	X	X	
Independent living skills training (subject to limitations specified in the approved 1115 waiver and TennCare Rule)	X	X	X	X	
Assistive technology, adaptive equipment and supplies (up to \$5,000 per calendar year)	X	X	X	X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)	X	X	X	X	X
Community support development, organization and navigation	X			X	
Family caregiver education and training (up to \$500 per calendar year)	X			X	
Family-to-family support	X			X	
Decision-making supports (up to \$500 per lifetime)	X	X	X	X	X
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X			X	

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Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Personal assistance (up to 215 hours per month)		X	X		
Community living supports (CLS)		X	X		
Community living supports—family model (CLS-FM)		X	X		
Individual education and training (up to \$500 per calendar year)		X	X		X
Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living (up to \$1,500 per lifetime)		X	X		X
Specialized consultation and training (up to \$5,000 per calendar year <sup>1</sup> )		X	X		X
Adult dental services (up to \$5,000 per calendar year; up to \$7,500 across three consecutive calendar years)	X <sup>2</sup>	X	X		X
Employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule)	X	X	X	X	X
<ul style="list-style-type: none"> <li>– Supported employment—individual employment support</li> <li>– Exploration</li> <li>– Benefits counseling</li> <li>– Discovery</li> <li>– Situational observation and assessment</li> <li>– Job development plan or self-employment plan</li> <li>– Job development or self-employment start up</li> <li>– Job coaching for individualized, integrated employment or self-employment</li> <li>– Co-worker supports</li> <li>– Career advancement</li> </ul>	X	X	X	X	X
Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS)				X	
<u>Intensive Behavioral Community Transition and Stabilization Services</u>					X

**6. Section A.2.6.1.6 shall be amended by deleting and replacing Sections A.2.6.1.6.4 and A.2.6.1.6.5 as follows:**

2.6.1.6.4 In addition to the benefits specified above which shall be delivered in accordance with the definitions, including limitations set forth in the approved 1115 waiver and in TennCare rule, a person enrolled in ECF CHOICES Groups 4, 5, and 6 may receive short-term nursing facility

<sup>1</sup> For adults in the Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to \$10,000 per person per calendar year.

<sup>2</sup> Limited to adults age 21 and older.

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care, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission. A person enrolled in ECF CHOICES Groups 7 and 8 shall not be eligible to receive short-term nursing facility care.

2.6.1.6.5 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Groups, 4, 5 and 6 members only when (1) the member is enrolled in ECF CHOICES Group 4, 5, or 6 and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 4, 5, and 6 members and shall ensure that the member is disenrolled from ECF CHOICES if a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for ECF CHOICES Group 4, 5, and 6. A person enrolled in ECF CHOICES Groups 7 or 8 is not eligible for a short-term NF stay and must be disenrolled from ECF CHOICES in order to receive Medicaid-reimbursed NF services.

**7. Section A.2.6.1.6.9 shall be amended deleting and replacing Sections A.2.6.1.6.9.2, A.2.6.1.6.9.3.1, A.2.6.1.6.9.3.2, and renumbered Section A.2.6.1.6.9.3.4, and adding new Sections A.2.9.6.1.6.9.2.1, A.2.6.1.6.9.2.2., A.2.6.1.6.9.3.2.1, A.2.6.1.6.9.3.2.2, A.2.6.1.6.9.3.2.3, A.2.9.6.1.6.3.3, A.2.6.1.6.9.3.4.1, A.2.6.1.6.9.4, and A.2.6.1.6.9.4.1, A.2.6.1.6.9.4.2, A.2.6.1.6.9.4.3, A.2.6.1.6.9.5, A.2.6.1.6.9.5.1, A.2.6.1.6.9.5.2, and A.2.6.1.6.9.5.3 as follows:**

2.6.1.6.9.2 Individuals receiving Group 5 benefits will be subject to a \$30,000 cap. The State may grant an exception for emergency needs up to \$6,000 in additional services per year, but shall not permit expenditures to exceed a hard cap of \$36,000 per calendar year, except that, for purposes of compliance with the federal HCBS Settings Rule, a member receiving Community Living Supports may be permitted to exceed the cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.

2.6.1.6.9.2.1 The exception applies *only* to newly requested Individual Employment Support benefits; previously approved Individual Employment Support benefits that have been provided within a member's Expenditure Cap shall not be shifted above the Expenditure Cap by adding other HCBS which are not eligible for this exception.

2.6.1.6.9.2.2 For a Group 5 member requiring a Community Stabilization and Transition rate of reimbursement for Community Living Supports (CLS), the higher cost of transitional CLS shall be excluded from the Group 5 member's Expenditure Cap for the year in which the transitional CLS are required, when a member is expected to be safely and appropriately served within the Group 5 Expenditure Cap, once transition to the appropriate ongoing CLS level occurs and the transitional rate ends.

2.6.1.6.9.3.1 Individuals in Group 6 with low need as determined by the State shall be subject to a \$45,000 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars (\$7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of \$52,500 per calendar year.

2.6.1.6.9.3.2 Individuals in Group 6 with moderate need as determined by the State shall be subject to a \$67,500 expenditure cap. The State may, on a case-by-case basis, grant an exception for

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emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars (\$7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of \$75,000 per calendar year.

- 2.6.1.6.9.3.2.1 Any exception for emergency or one-time needs that may be granted shall apply only for the calendar year in which the exception is approved.
- 2.6.1.6.9.3.2.2 For purposes of compliance with the federal HCBS Settings Rule, a member receiving Community Living Supports may be permitted to exceed the \$75,000 hard cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.
- 2.6.1.6.9.3.2.3. This exception shall apply *only* to newly requested Individual Employment Support benefits. Previously approved Individual Employment Support benefits that have been provided within a member's Expenditure Cap shall not be shifted above the Expenditure Cap by adding other HCBS which are not eligible for this exception.
- 2.6.1.6.9.3.3 Individuals with high need as determined by the State shall be subject to a \$88,250 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars (\$7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of \$95,750 per calendar year.
- 2.6.1.6.9.3.4 The State may grant an exception as follows: for individuals with DD and exceptional medical/behavioral needs as determined by the State, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with ID and exceptional medical/behavioral needs as determined by the State, up to the average cost of private ICF/IID services.
- 2.6.1.6.9.3.4.1. No exceptions to the Expenditure Cap shall be permitted for individuals with exceptional medical/behavioral needs as determined by the State. When a member's Expenditure Cap is based on the comparable cost of institutional care (an individual cost neutrality cap), the member's Expenditure Cap shall not be exceeded.
- 2.6.1.6.9.4 Individuals receiving Group 7 benefits shall be subject to an expenditure cap based on the comparable cost of institutional care as determined by TENNCARE.
- 2.6.1.6.9.4.1 Any home health or PDN services the member receives shall be counted against the expenditure cap.
- 2.6.1.6.9.4.2 While integrated in the delivery system, behavioral health services (other than IBFCTSS) shall not be counted against the expenditure cap.
- 2.6.1.6.9.4.3 No exceptions to the expenditure cap shall be permitted for individuals in ECF CHOICES Group 7.
- 2.6.1.6.9.5 Individuals receiving Group 8 benefits shall be subject to an expenditure cap based on the comparable cost of institutional care, as determined by TENNCARE, which may as determined appropriate, take into account the cost of short-term inpatient psychiatric hospitalization or other restrictive treatment setting for which the CONTRACTOR would otherwise be responsible for payment.
- 2.6.1.6.9.5.1. Any home health or PDN services the member receives shall be counted against the expenditure cap.

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2.6.1.6.9.5.2. While integrated in the delivery system, behavioral health services (other than IBCTSS) will not be counted against the expenditure cap.

2.6.1.6.9.5.3. No exceptions to the expenditure cap shall be permitted for individuals in ECF CHOICES Group 8.

**8. Section A.2.6.1.6.12 shall be amended by deleting and replacing Sections A.2.6.1.6.12.1, A.2.6.1.6.12.2, A.2.6.1.6.12.3, and A.2.6.1.6.12.4 as follows:**

2.6.1.6.12.1 A member in any ECF CHOICES Group for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member's expenditure cap when the member is unable or unwilling to transition to a different ECF CHOICES Group in which the member's needs could be safely and effectively met within the expenditure cap that would be applied in that Group;

2.6.1.6.12.2 A member in any ECF CHOICES Group who repeatedly refuses to allow a Support Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.6.12.3 A member in any ECF CHOICES Group who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP; and

2.6.1.6.12.4 A member in any ECF CHOICES Group who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Division of TennCare has determined that no other MCO is willing to serve the member.

**9. Section A.2.6.5.2.5 shall be amended as follows:**

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2 or Group 3 or ECF CHOICES, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars (\$2,000). The allowance may be used for rent and/or utility deposits (rental security deposits required to obtain a lease—e.g., first and last month's rent—may be covered even if not refundable; ongoing rent may not), essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. In provider-owned settings (including settings which the provider owns, co-owns, has any ownership interest in, or has any affiliation with the entity that owns the home in which the member will reside), the transition allowance shall only be used for household items and furnishings that are for the member's personal use, such as bedroom furniture, towels, linens, sheets, and other similar items as approved by TENNCARE. A transition allowance shall not be used for rent or for household items and furnishings for common use of all persons residing in the home. Regardless of setting, items purchased as part of the Transition Allowance shall be the personal property of the member, not the provider. When the CONTRACTOR elects to provide a Transition Allowance to a member transitioning to CHOICES Group 3 or ECF CHOICES, the amount of the Transition Allowance shall be applied to the member's Expenditure Cap.

**10. Section A.2.6.5.3 shall be amended as follows:**

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES or ECF CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care exceed the member's Expenditure Cap for Group 2 exceed a member's cost neutrality cap. In no case shall the cost of ECF CHOICES HCBS, private duty nursing and home health care for members in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on the comparable cost of institutional care. For CHOICES members enrolled in Group 3 and ECF CHOICES members, the total cost of CHOICES HCBS or ECF CHOICES, as applicable, excluding, for members in Group 3 and Group 4 the cost of minor home modifications, shall not exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care for CHOICES Group 2 members pursuant to Section A.2.6.5.2 of this Contract including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for CHOICES Group 1 members who are transitioning to CHOICES Group 2 or Group 3, and NEMT for Groups 2 and 3. The total cost of ECF CHOICES HCBS includes all covered ECF CHOICES HCBS and other non-covered services the CONTRACTOR elects to offer as a cost-effective alternative to nursing facility care for members who meet nursing facility level of care, including a transition allowance, or to other covered benefits for all ECF CHOICES members, including ECF CHOICES HCBS in excess of specified benefit limits.

**11. Section A.2.7.3 shall be amended as follows:**

**A.2.7.3 Self-Direction of Health Care Tasks**

The CONTRACTOR shall, in accordance with TennCare rules and regulations, permit CHOICES or ECF CHOICES members the option to direct and supervise a consumer-directed worker who is providing eligible CHOICES or ECF CHOICES HCBS in the performance of health care tasks.

**12. Sections A.2.7.6.4.8.4 and A.2.7.6.4.8.5 shall be amended as follows:**

2.7.6.4.8.4 **Note 4:** Certain services are covered under a Home and Community Based Services Program (i.e., ECF CHOICES or a 1915(c) Waiver) but are **not TennCare Kids services** because they are not listed in the Social Security Act Section 1905(a). These services include, but are not limited to, habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)

2.7.6.4.8.5 **Note 5:** Certain services are not coverable even under a Home and Community Based Services Program and are **not TennCare Kids services**. These services include, but are not limited to, room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

**13. Section 2.8 shall be deleted and replaced as follows, including any references as appropriate:**

**A.2.8 POPULATION HEALTH**

**A.2.8.1 General**

2.8.1.1 The CONTRACTOR shall establish and operate an integrated Population Health Program based upon risk stratification of the CONTRACTOR population. The Population Health Model touches members across the entire care continuum, promoting healthy behaviors and disease self-management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices. The CONTRACTOR shall evaluate the entire member population and identify members for specific programs according to risk rather than disease specific categories. This approach shall include the following risk levels and programs:

2.8.1.1.1 **Risk Level 0:** Wellness Program

2.8.1.1.2 **Risk Level 1:** Low Risk Maternity, Health Risk Management and Care Coordination programs; and

2.8.1.1.3 **Risk Level 2:** Chronic Care Management, High Risk Pregnancy and Complex Case Management programs

**A.2.8.2 Member Identification /Stratification Strategies**

2.8.2.1 The CONTRACTOR shall utilize a combination of predictive modeling utilizing claims data, pharmacy data, and laboratory results, supplemented by referrals, UM data, and/ or health risk assessment results to stratify the member population. The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's member population at a minimum quarterly. The member population shall be stratified into the following risk categories:

2.8.2.1.1 Level 0- The members eligible to participate at this level shall be determined by predictive modeling to meet ALL of the following criteria: no identified health risks; no identified chronic conditions [as identified by the Chronic Condition tool created by the Agency for Healthcare Research and Quality's (AHRQ) HCUP database]; and no indication of pregnancy; or no claims history. CHOICES and ECF CHOICES members with no claims data may be included in Level 0 until claims data is received or until member is stratified into the appropriate health risk level.

2.8.2.1.2 Level 1- The members eligible to participate at this level are members that do not meet the Level 0 or Level 2 criteria; or all members that meet Level 2 criteria who cannot be contacted by the processes referenced in Sections A.2.8.4.5.2, A.2.8.4.6.2, A.2.8.4.7.2 of this Contract, or those members that are eligible for Level 2 program enrollment but elect not to enroll in a Level 2 program.

2.8.2.1.2.1 All members identified as Level 1, through predicative modeling, and not pregnant are eligible for the Health Risk Management Program. At a minimum, the CONTRACTOR shall enroll members with chronic diseases that are prevalent in a significant number of members, or members with other chronic diseases utilizing significant health resources in their regional population.

2.8.2.1.2.1.1 The CONTRACTOR shall sub-stratify members identified for the Health Risk Management Program into Low, Medium, and High categories based on criteria developed by the CONTRACTOR and reported in the annual Program Description. The CONTRACTOR shall

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- provide the minimum interventions for each category as outlined in Section A.2.8.4.3 of this Contract.
- 2.8.2.1.2.2 The CONTRACTOR shall identify members for the Level 1, Care Coordination Program through referrals, hospital and ED face sheets, and any other means of identifying members with acute healthcare needs, health service needs, or risks which need immediate attention.
- 2.8.2.1.2.3 The CONTRACTOR shall place all Level 2 members who cannot be contacted by the process referenced in Section A.2.8.4.5.2 of this Contract, or chose not to enroll in a Level 2 program, in Level 1 programs.
- 2.8.2.1.3 Level 2 – Members eligible to participate at this level shall be determined by predictive modeling identifying approximately the top three percent (3%) of members, excluding High Risk Maternity members, to be most at risk for adverse health outcomes, and/or by referrals or health risk assessments.
- 2.8.2.1.3.1 The CONTRACTOR shall identify members for the **Chronic Care Management Program** from those Level 2 members that are not pregnant but have complex chronic conditions with multiple identified health risks and or needs. This may include those members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members may also be identified for Chronic Care Management by referrals and health risk assessments.
- 2.8.2.1.3.2 The CONTRACTOR shall identify members for the **Complex Case Management Program** from those Level 2 members that are not pregnant and have high risk, unique or complex needs. These may include members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members identified by utilization reports as high pharmacy user or those members which exceed the ED threshold, as defined by TENNCARE, shall be reviewed for need for case management. Members may also be identified for Complex Case Management by referrals and health risk assessments.
- 2.8.2.1.4 The CONTRACTOR shall systematically stratify newly enrolled members on a monthly basis.
- 2.8.2.1.5 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population to identify approximately the top 3% as defined in Section A.2.8.2.1.4 of this Contract at a minimum of quarterly intervals to insure members with increasing health risks and needs are identified for Level 2 programs.
- 2.8.2.2 The CONTRACTOR shall identify **pregnant members** through claims, referrals, and the 834 nightly feed, as well as through any other method identified by health plan.
- 2.8.2.2.1 The CONTRACTOR will stratify pregnant members into either Low or High Risk Maternity Programs based on the CONTRACTOR's obstetrical assessment. Pregnant members identified as substance abusers, including tobacco users, or who meet other high risk indicators shall be stratified as high risk. Pregnant members who, through the OB assessment, do not meet high risk needs, and members who are identified for High Risk Maternity Program but choose not to participate, shall be enrolled in the Low Risk Maternity Program .

**A.2.8.3 Member Assessment**

- 2.8.3.1 The CONTRACTOR shall make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment, also referred to as a health risk appraisal, that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard, that has been approved by TENNCARE and Population Health staff, or a comprehensive health risk assessment that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard. The CONTRACTOR shall make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful, within thirty (30) days of the initial outreach attempt. These timelines may be shortened or contact methods specified for specific parts of the program in contract sections below. The information collected from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.
- 2.8.3.2 At time of enrollment and annually thereafter, the CONTRACTOR shall make a reasonable attempt to assess the member's health. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the approved health assessment required by the contract. Members exempt from the health assessment are those members that have completed an approved health assessment or a comprehensive health risk assessment in the prior twelve (12) months. The completed approved health assessment or comprehensive health risk assessment data may be shared among TennCare MCOs and used to meet the annual requirement. At the request of TENNCARE, the CONTRACTOR shall share with TENNCARE, or other MCCs serving the member, the results of any identification and assessment of that member's needs to assist in facilitating the administration of health related services and to prevent duplication of those activities.
- 2.8.3.3 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment (HRA) for all members enrolled in the Chronic Care Management, Complex Case Management, and High Risk Maternity Programs. The HRA should include screening for physical conditions, mental health, and substance abuse for all members.
- 2.8.3.4 For members considered high risk, the assessment shall include documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators).
- 2.8.3.5 The CONTRACTOR shall conduct an assessment for the need of a face to face visit for members considered to have high health risks that are enrolled in the Chronic Care Management, Complex Case Management, or High Risk Maternity programs. The CONTRACTOR shall assess the need for a face-to-face visit using the standard assessment criteria provided by TENNCARE. If needed, such a visit shall be conducted following consent of the member.

**A.2.8.4 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

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increases. 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.

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 as long as possible.

2.8.4.1.1 The CONTRACTOR shall operate its Wellness Program using an “opt out” methodology. Program services shall be provided to all eligible members unless they specifically ask to be excluded.

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

2.8.4.1.3 The CONTRACTOR shall provide to members eligible for the **Wellness Program** the following minimum intervention:

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

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 develop and operate the Low Risk Maternity Program as an “opt out” program. Program services shall be provided to eligible members unless they specifically ask to be excluded

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

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

<b>Low Risk Maternity Program Minimum Interventions</b>	
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.2.8.4.5.2 of this Contract.
2.	Prenatal packets (considered the one non-interactive intervention to the member for the duration of the pregnancy) to include at a minimum: <b>A.</b> Encouragement to access Text4Baby <b>B.</b> Access number to maternity nurse/social worker if member would like to engage in monthly maternity management <b>C.</b> Preterm labor education <b>D.</b> Breast feeding <b>E.</b> Secondhand smoke <b>F.</b> Safe sleep <b>G.</b> Specific trimester health information <b>H.</b> Importance of postpartum visit <b>I.</b> Importance of screening for postpartum depression <b>J.</b> Help Us Grow Successfully (HUGS)/CHANT TDH program information <b>K.</b> Inter-conception health, to include dangers of becoming pregnant while using narcotics
3.	Follow up as appropriate to determine the status of a prenatal visit to those members who received an initial assessment but had not scheduled or completed their first prenatal visit.
4.	Follow-up to all eligible members, to assess the status of a postpartum visit appointment and assist them with making their appointment if needed.

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 healthy behaviors (i.e. weight management and tobacco cessation), self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers.

2.8.4.3.2 The CONTRACTOR shall develop and operate the Health Risk Management Program as an “opt out” program. Program services shall be provided to eligible members unless they specifically ask to be excluded..

2.8.4.3.3 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.2.8.4.3.7 of this Contract.

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2.8.4.3.4 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.

2.8.4.3.5 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.

2.8.4.3.6 The CONTRACTOR shall sub-stratify populations within the Health Risk Management Program (Low, Medium, High ) based upon identified risk, lifestyle choices (tobacco or substance use), referrals, and identified needs. Interventions for each subpopulation shall be based on risk level or the identified modifiable health risk behavior.

2.8.4.3.7 The CONTRACTOR shall provide to members in the lowest risk level of the Health Risk Management Program the following minimum standard interventions:

Health Risk Management Program: <b><u>Lowest Risk Level</u></b> Minimum Interventions	
1.	<u>One</u> documented non-interactive communication each year. The communication shall address self-management education emphasizing the following: 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
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections A.2.8.4.3.4 and A.2.8.4.3.5 of this Contract.

2.8.4.3.8 The CONTRACTOR shall provide to members in the medium risk level within the Health Risk Management Program the following minimum standard interventions:

Health Risk Management Program: <b><u>Medium Risk Level</u></b> Minimum Interventions	
1.	Two documented non-interactive communications each year which shall emphasize self-management education addressing the following: A. Members knowledge of chronic health conditions B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of health conditions E. Self-efficacy & support
2.	Offering of interactive communications for self-management if need is

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	identified and member desires to become engaged.
3.	Availability of 24/7 NurseLine.
4.	Health coaching to provide self-management education and support if the need is identified or as requested by eligible members.
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections A.2.8.4.3.4 and A.2.8.4.3.5 of this Contract.

2.8.4.3.9 The CONTRACTOR shall provide to members in the highest risk level within the Health Risk Management Program the following minimum interventions:

Health Risk Management Program: <b>Highest Risk Level</b> Minimum Interventions	
1.	<p><u>Four</u> documented non-interactive communications each year which shall emphasize the following:</p> <ul style="list-style-type: none"> <li>A. Members knowledge of chronic health conditions</li> <li>B. Importance of medication adherence</li> <li>C. Appropriate lifestyle/behavioral changes</li> <li>D. Management of emotional aspects of health conditions</li> <li>E. Self-efficacy &amp; support</li> </ul>
2.	<p>Offering of interactive communications for self-management if need is identified and member desires to become engaged which may include:</p> <ul style="list-style-type: none"> <li>A. Documented action plan as appropriate if the need is identified or upon request of eligible members</li> <li>B. Referrals and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs</li> <li>C. Monitoring and follow up which shall consist of activities and contacts that are necessary to ensure services, appointments and community resources were furnished as planned and shall be appropriately documented for reporting purposes</li> <li>D. Defined monitoring for gaps in care</li> </ul>
3.	Availability of 24/7 NurseLine
4.	Health coaching to provide self-management education and support if the need is identified or as requested by eligible members
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections A.2.8.4.3.4 and A.2.8.4.3.5

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 develop and operate the Chronic Care Management Program using an “opt out” methodology per NCQA standard PHM 5: Complex Case Management. Program services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.4.5.2 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.

2.8.4.5.3 Engagement rates for the Chronic Care Management program will be monitored by TENNCARE with baseline determined the first year with improvement from baseline expected in subsequent years. The NCQA Minimum Effect Size Change methodology will serve as the measurement of improvement in subsequent years.

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

<b>Chronic Care Management Program Minimum Interventions</b>	
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"> <li>A. Development of a supportive member and health coach relationship</li> <li>B. Disease specific management skills such as medication adherence and monitoring of the member’s condition</li> <li>C. Negotiating with members for appropriate health and behavioral changes</li> <li>D. Problem solving techniques</li> <li>E. The emotional impact of member’s condition</li> <li>F. Self-efficacy</li> <li>G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs</li> <li>H. Regular and sustained monitoring and follow-up</li> </ul>
2.	Clinical reminders related to gaps in care.
3.	Suggested elements of the member’s plan of care.
4.	Provision of after hour assistance with urgent or emergent needs.

2.8.4.5.5 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**

Amendment 9 (cont.)

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 develop and operate the High Risk Maternity Program using an “opt out” methodology per NCQA standard PHM 5: Complex Case Management. Program services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.4.6.2 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.2 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.

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

<b>High Risk Maternity Program Minimum Interventions</b>	
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.
	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.	Provide prenatal packets including:
	Encouragement to enroll in Text4Baby.
	Encouragement (social marketing) to enroll in High Risk Maternity program.
	Information on preterm labor education.
	Information on breast feeding.
	Information on secondhand smoke.
	Information on safe sleep.
	Trimester specific health information.
	Information on importance of postpartum visit.
	Information on postpartum depression.
	Help Us Grow Successfully (HUGS)/CHANT TDH program information.
Information on inter-conception health, including dangers of becoming	

	pregnant while using narcotics and long term contraception.
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**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 develop and operate the Complex Case Management Program using an “opt out” methodology per NCQA standard PHM 5: Complex Case Management. Program services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.4.7.2 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.2 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.

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

2.8.4.7.4 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment to assess member’s needs to include screening for mental health and substance abuse for all members identified with a physical condition and screening for physical conditions when member’s condition is behavioral.

2.8.4.7.5 The CONTRACTOR shall provide defined ongoing member assessment for the need to move these members into a lower risk classification or into the Chronic Care Management Program.

2.8.4.7.6 The CONTRACTOR shall provide to members enrolled in the Complex Case Management Program the following:

<b>Complex Case Management Program Minimum Interventions</b>	
1.	Monthly interactive member contacts to provide individual self-management support emphasizing the following:
	One face –to –face visit as deemed appropriate by MCO
	Development of a supportive member and health coach relationship
	Teaching disease specific management skills such as medication adherence and monitoring of the member’s condition
	Negotiating with members for appropriate health and behavioral changes
	Providing problem solving techniques
	Assist with the emotional impact of the member’s condition
	Self-efficacy
	Providing regular and sustained monitoring and follow-up
	Referral and linkages
2.	Providing clinical reminders around HEDIS/gaps in care
3.	Providing after hours assistance with urgent or emergent member needs

**A.2.8.5 Program Description**

The CONTRACTOR shall develop and maintain a Population Health Program Description following the guidance documents issued by the Division of TennCare, Quality Oversight Division, which must be submitted for review by the Quality Oversight Division on an annual basis.

**A.2.8.6 Clinical Practice Guidelines**

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

**A.2.8.7 Informing and Educating Members**

The CONTRACTOR shall inform all members of the availability of Population Health Programs and how to access and use the program services. The member shall be provided information regarding their eligibility to participate, how to self-refer, and how to appropriately “opt out” of a program.

**A.2.8.8 Informing and Educating Practitioners**

The CONTRACTOR shall educate providers regarding the operation and goals of all Population Health programs. The providers should be given instructions on how to access appropriate services as well as the benefits to the provider. For members receiving interactive interventions, the CONTRACTOR shall notify the practitioners by letter, email, fax, or via a secure web portal of their patient’s involvement.

**A.2.8.9 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.2.8.10 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.

2.8.10.1 The CONTRACTOR’s Population Health Program description shall describe 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.

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- 2.8.10.2 The CONTRACTOR's Population Health Program description 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.
- 2.8.10.3 The CONTRACTOR's program description shall also include the method for addressing the following for CHOICES or ECF CHOICES members:
- 2.8.10.3.1 Notifying the CHOICES Care Coordinator or ECF CHOICES Support Coordinator of the member's participation in a Population Health Program;
- 2.8.10.3.2 Providing member information collected to the CHOICES Care Coordinator or ECF CHOICES Support Coordinator;
- 2.8.10.3.3 Provide to the CHOICES Care Coordinator or ECF CHOICES Support Coordinator any educational materials given to the member through these programs;
- 2.8.10.3.4 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;
- 2.8.10.3.5 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
- 2.8.10.3.6 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).
- 2.8.10.4 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.

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- 2.8.10.4.1 Targeted methods for informing and educating CHOICES and ECF CHOICES members shall not be limited to mailing educational materials.
- 2.8.10.5 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.
- 2.8.10.6 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.
- 2.8.10.7 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:
  - 2.8.10.7.1 The member will be informed by CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;
  - 2.8.10.7.2 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;
  - 2.8.10.7.3 The Population Health Complex Case Manager will be responsible for developing a service plan for the home setting;
  - 2.8.10.7.4 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
  - 2.8.10.7.5 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.2.8.11 Evaluation**

- 2.8.11.1 The CONTRACTOR shall collect and report process and outcome data as indicated on Population Health quarterly and annual report templates provided by TENNCARE. Outcome data for these reports will include short, intermediate and long term measures.

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- 2.8.11.2 The CONTRACTOR shall provide in the annual report for the programs, with interactive interventions, an active participation rate as designed by NCQA.
- 2.8.11.3 The CONTRACTOR shall evaluate and report member satisfaction based upon NCQA requirements, on Population Health programs with interactive interventions.
- 2.8.11.4 The CONTRACTOR shall assess member's functional status, using the SF12 survey, or other appropriate tool used for children or the intellectually disabled, for members in the high risk Chronic Care Management program and the Complex Case Management program.

**A.2.8.12 Special Projects**

- 2.8.12.1 As appropriate, the CONTRACTOR's Population Health staff shall participate in a collaborative MCO/TennCare workgroup to evaluate and address innovative ways to improve member health outcomes.
- 2.8.12.2 The CONTRACTOR shall conduct at least two rapid cycle improvement projects annually. One rapid cycle improvement project shall address increasing member engagement rates in the High Risk level of Population Health programs. The second rapid cycle engagement project shall address engaging members to make behavioral changes such as weight loss, or smoking cessation. The project plans are to be reported in the quarterly report before implementation. The projects should then be conducted with the results to be reported in the next Population Health Quarterly Report.

**14. Section A.2.9.1.1 shall be amended as follows:**

- 2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility. For CHOICES and ECF CHOICES members, these policies and procedures shall specify the role of the Care Coordinator/care coordination or Support Coordinator/support coordination team, or the Integrated Support Coordination Team, as applicable, in conducting these functions (see Section A.2.9.6).

**15. Section A.2.9.2.1.4 shall be amended by amending Sections A.2.9.2.1.4.1, A.2.9.2.1.4.2, and A.2.9.2.1.4.3 as follows:**

- 2.9.2.1.4.1 For a member in CHOICES Group 2 or 3 or ECF CHOICES, the CONTRACTOR shall continue CHOICES or ECF CHOICES HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce these services unless a Care Coordinator or Support Coordinator, as applicable, has conducted a comprehensive needs assessment and developed a plan of care or PCSP, and the CONTRACTOR has authorized and initiated CHOICES or ECF CHOICES HCBS in accordance with the member's new plan of care or PCSP. If a member in CHOICES Group 2 or 3 or ECF CHOICES Group 4, 5, or 6 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14); however, the member may be transitioned to the community in accordance with Section A.2.9.6.8 of this Contract.

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2.9.2.1.4.2 For a member in CHOICES Group 2 or 3 or ECF CHOICES transferring from another MCO, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a Care Coordinator or Support Coordinator, as applicable, shall conduct a face-to-face visit (see Section A.2.9.6.2.5), including a comprehensive assessment (see Section A.2.9.6.5) and a caregiver assessment, and develop a plan of care or PCSP, as applicable (see Section A.2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS or ECF CHOICES HCBS in accordance with the new plan of care or PCSP (see Section A.2.9.6.2.5). If a member in Group 2 or 3 or ECF CHOICES Group 4, 5, or 6 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a Care Coordinator or Support Coordinator, as applicable, shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate comprehensive assessment and care planning activities (see Section A.2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 or ECF CHOICES and Section A.2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate prior to the member's exhaustion of the 90-day short-term NF benefit.

2.9.2.1.4.3 If at any time before conducting a comprehensive assessment for a member in CHOICES Group 2 or 3 or ECF CHOICES, the CONTRACTOR becomes aware of an increase in the member's needs, a Care Coordinator, Support Coordinator, or the Integrated Support Coordination Team, as applicable, shall immediately conduct a comprehensive assessment and update the member's plan of care or PCSP, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs.

**16. Section A.2.9.2.5 shall be amended as follows:**

2.9.2.5 If the CONTRACTOR becomes aware that a CHOICES or ECF CHOICES member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the member's Care Coordinator or care coordination team or Support Coordinator or support coordination team, or the Integrated Support Coordination Team, as applicable) shall, in accordance with protocols established by TENNCARE, work with the other MCO in facilitating a seamless transition for that member.

**17. Section A.2.9.6.1.10 shall be amended as follows:**

2.9.6.1.10 The CONTRACTOR shall ensure that, upon enrollment into CHOICES or ECF CHOICES, the appropriate level of Population Health (see Section A.2.8.4 of this Contract) activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports needs. The Care Coordinator, Support Coordinator, or Integrated Support Coordination Team may use resources and staff from the CONTRACTOR's Population Health programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the Care Coordinator/care coordination, Support Coordinator/support coordination team, or Integrated Support Coordination Team, as applicable.

**18. Section A.2.9.6.2.3 shall be amended to add a new Section A.2.9.6.2.3.13 as follows:**

2.9.6.2.3.13 The CONTRACTOR shall complete all intake processes in Section A.2.9.6.2 within thirty (30) calendar days, unless an exception is granted by TENNCARE in writing due to extenuating circumstances beyond the CONTRACTOR's control. If TENNCARE grants an exception, such exception will provide the CONTRACTOR an additional thirty (30) calendar days to complete an intake process for the applicant, totaling sixty (60) calendar days to complete the intake process. If TENNCARE grants the CONTRACTOR an exception and the CONTRACTOR does not complete the intake process within sixty (60) calendar days, the CONTRACTOR shall close the referral and document the reason(s) the intake process was not completed for that applicant, and shall maintain such documentation and provide the documentation to TENNCARE upon request.

**19. Section A.2.9.6.2.4.5 shall be amended as follows:**

2.9.6.2.4.5 The CONTRACTOR shall be responsible for monitoring the member's continued need for and receipt of skilled and/or rehabilitative services in a NF only when approval of NF LOC is conditioned on the receipt of such services, and in such case, when skilled and/or rehabilitative services are no longer medically necessary, shall submit information needed by TENNCARE to reevaluate whether the member continues to meet level of care for nursing facility services (see also Section A.2.14.1.14).

**20. Section A.2.9.6.2.5.3 shall be amended by amending Section A.2.9.6.2.5.3, A.2.9.6.2.5.3.2, and A.2.9.6.2.5.3.4 as follows:**

2.9.6.2.5.3 For CHOICES and ECF CHOICES members, the Support Coordinator, Care Coordinator, or Integrated Support Coordination Team, as applicable, shall conduct a face-to-face visit with the member, initiate a comprehensive assessment in a manner sufficient to ensure strengths, needs, opportunities, and challenges are identified and addressed as set forth below, and conduct a caregiver assessment, and authorize and initiate CHOICES HCBS and ECF CHOICES HCBS as described and in accordance with timeframes specified in this section.

2.9.6.2.5.3.2 For ECF CHOICES members, the CONTRACTOR shall determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed. Immediately needed ECF CHOICES HCBS may include (but are not limited to) services that a person needs in order to facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment. Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS) and Intensive Behavioral Community Transition and Stabilization Services shall be considered "immediately needed" services. The CONTRACTOR may utilize other covered benefits or cost-effective alternative services as needed to address immediate needs while ECF CHOICES services are put into place, or provide incentives to providers with prior approval from TENNCARE to provide such immediately needed services and to put in place sustainable strategies to enable the provider to do so on ongoing basis. The CONTRACTOR shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment, or as expeditiously as needed to facilitate timely discharge, avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such

employment. In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services). Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly. For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall first address, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.

2.9.6.2.5.3.4 The Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall, within thirty (30) calendar days of notice of enrollment in CHOICES or ECF CHOICES, complete the comprehensive assessment (see A.2.9.6.5.2.5), develop the PCSP, and authorize and initiate services as specified in the PCSP, except when a later date, for one or more specified services, is requested by the member which shall be documented in writing in the manner prescribed by TennCare, including but not limited to, (1) when an ECF CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim; or (2) a member requests additional time to complete person-centered planning processes, select a provider and/or staff that are best aligned with his or her goals, needs, and preferences, or visit and select from available options or develop a Community Living Supports living arrangement. In non-urgent circumstances, which shall be distinct from those described in A.2.9.6.2.5.3.2, "initiation" may also take into account the time required by the selected provider to hire and train qualified staff if the CONTRACTOR has informed the member of any providers with existing trained staff available to initiate the service and the member has declined those providers. In this case, services shall be considered "initiated" if a provider has been selected by the member, the services have been authorized by the CONTRACTOR, the provider has agreed to provide the requested service(s), and the CONTRACTOR verifies that the provider is actively engaged in hiring and/or training staff to provide the requested services. The CONTRACTOR shall be responsible for ongoing follow-up with the provider selected by the member to ensure that these processes are completed timely and services commence. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate.

**21. Section A.2.9.6.3 shall be amended by amending Sections A.2.9.6.3.26, A.2.9.6.3.26.2, A.2.9.6.3.26.3, and A.2.9.6.3.27 as follows:**

2.9.6.3.26 For CHOICES and ECF CHOICES members, the Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall complete a comprehensive assessment in a manner sufficient to ensure strengths, needs, opportunities, and challenges are identified and addressed in the PCSP, and conduct a caregiver assessment, and authorize and initiate CHOICES HCBS and ECF CHOICES HCBS as described and in accordance with timeframes specified in this section.

2.9.6.3.26.2 For ECF CHOICES members, the CONTRACTOR shall determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed. Immediately needed ECF CHOICES HCBS may include but are not limited to services that a person needs in order to facilitate timely discharge from an inpatient setting or to prevent inappropriate placement

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in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment. Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS) and Intensive Behavioral Community Transition and Stabilization Services shall be considered "immediately needed" services. The CONTRACTOR may utilize other covered benefits or cost-effective alternative services as needed to address these immediate needs while ECF CHOICES services are put into place or provide incentives to providers with prior approval from TENNCARE to provide such immediately needed services and to put in place sustainable strategies to enable the provider to do so on ongoing basis. The CONTRACTOR shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment or as expeditiously as needed to facilitate timely discharge or avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such employment. In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services). Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly. For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall address first, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.

- 2.9.6.3.26.3 The Support Coordinator or Care Coordinator, as applicable, shall, within thirty (30) calendar days of notice of enrollment in CHOICES or ECF CHOICES, complete the comprehensive assessment (see A.2.9.6.5) and develop the PCSP and authorize and initiate services as specified in the PCSP except when a later date is requested, for one or more specified services, by the member which shall be documented in writing (e.g., these shall include but are not limited to, (1) when an ECF CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim, or (2) a member requests additional time to complete person-centered planning processes, select a provider and/or staff that are best aligned with his or her goals, needs, and preferences, or visit and select from available options or develop a Community Living Supports living arrangement. In non-urgent circumstances, which shall be distinct from those described in 2.9.6.2.5.3.2, "initiation" may also take into account the time required by the provider to hire and train qualified staff if the CONTRACTOR has informed the member of any providers with existing trained staff available to initiate the service and the member has declined those providers. In this case, services shall be considered "initiated" if a provider has been selected by the member, the services have been authorized by the CONTRACTOR, the provider has agreed to provide the requested service(s), and the CONTRACTOR verifies that the provider is actively engaged in hiring and/or training staff to provide the requested services. The CONTRACTOR shall be responsible for ongoing follow-up with the provider selected by the member to ensure that these processes are completed timely and services commence. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate.

2.9.6.3.27 For the CONTRACTOR's members enrolled into CHOICES Group 2 or Group 3 or ECF CHOICES, the member's Care Coordinator or Support Coordinator, as applicable, shall, within the timeframes prescribed in this section, authorize and initiate CHOICES or ECF CHOICES HCBS, as applicable.

**22. Section A.2.9.6.3 shall be amended by amending Section A.2.9.6.3.19.4 and by adding a new Section A.2.9.6.3.30 as follows:**

2.9.6.3.19.4 The CONTRACTOR must submit the PAE to TENNCARE within twenty (20) business days from the date of the enrollment visit regardless of whether the CONTRACTOR has received the supporting documentation. After submitting the PAE to TENNCARE, if the PAE submission results in a denial or the inability to approve the level of care indicated on the PAE if supporting documentation had been submitted to support such approval, the CONTRACTOR shall continue diligent efforts to collect supporting documentation as specified in Section A.2.9.6.3.18.2. Pursuant to TennCare Rules, if within thirty (30) calendar days of the initial PAE submission, the CONTRACTOR obtains additional supporting documentation, the CONTRACTOR shall submit a revised PAE with the supporting documentation. After thirty (30) calendar days from the initial PAE submission have passed, the CONTRACTOR shall have no obligation to make efforts to collect supporting documentation, but shall be required to submit a new PAE with supporting documentation to TENNCARE if such documentation is subsequently received.

2.9.6.3.30 The CONTRACTOR shall complete all intake processes in Section A.2.9.6.3 within thirty (30) calendar days, unless an exception is granted by TENNCARE in writing due to extenuating circumstances beyond the CONTRACTOR's control. If TENNCARE grants an exception, such exception will provide the CONTRACTOR an additional thirty (30) calendar days to complete an intake process for the applicant, totaling sixty (60) calendar days to complete the intake process. If TENNCARE grants the CONTRACTOR an exception and the CONTRACTOR does not complete the intake process within sixty (60) calendar days, the CONTRACTOR shall close the referral and document the reason(s) the intake process was not completed for that applicant, and shall maintain such documentation and provide the documentation to TENNCARE upon request.

**23. Section A.2.9.6.4.3 shall be amended as follows:**

2.9.6.4.3 The CONTRACTOR shall assign to each member a specific Care Coordinator or Support Coordinator who shall have primary responsibility for performance of care coordination or support coordination activities as specified in this Contract, and who shall be the member's point of contact for coordination of all physical health, behavioral health, and long-term services and supports. Members in ECF CHOICES Groups 7 and 8 shall be assigned a specific Integrated Support Coordination Team, as defined herein.

**24. Section A.2.9.6.5 shall be amended by amending Sections A.2.9.6.5.2.5, A.2.9.6.5.2.5.2 and A.2.9.6.5.2.6.1.1 as follows:**

2.9.6.5.2.5 For ECF CHOICES members

2.9.6.5.2.5.2 At minimum, for members in ECF CHOICES, the comprehensive assessment shall assess: (1) the member's strengths; (2) the natural and community supports (both currently involved and yet to be involved) available to the member, and the extent of the stability of each of those supports; (3)

the member's preferences for lifestyle, employment, daily routine and community involvement, privacy, and direct support professionals; (4) the member's goals and needs related to: achieving his/her desired lifestyle and personal goals (including employment and community involvement goals); achieving and maintaining the best possible health and wellness; preserving and building natural and community supports; developing and maintaining a network of chosen and positive relationships; building skills and strategies for independence; achieving the greatest possible financial capabilities to maximize the member's ability to control personal income and other financial resources; understanding and exercising his/her rights, preserving guardianship of self, executing advance directives, utilizing durable power of attorney and/or power of attorney for health care; obtaining and maintaining safe, stable and affordable housing; building and preserving financial health; and mitigating risks associated with the member's desired lifestyle, chosen relationships, housing situation and/or impact of disability; (5) the member's overall wellness including physical, behavioral, functional, and psychosocial needs; (6) on-going clinical and/or functional conditions that may require intervention, a course of treatment and/or on-going monitoring; (7) any vulnerability and risk factors for abuse and neglect in the member's personal life or finances; (8) services or assistance programs the member may be receiving, may have access to and/or may be eligible for, in addition to, or in lieu of, services available through ECF CHOICES; and (9) supports, services, or items necessary to enable the member to achieve his/her preferred lifestyle and goals, to ensure community living, to facilitate gainful integrated employment, and to delay or prevent a decline in level of independence and functioning.

2.9.6.5.2.6.1.1 The Care Coordinator or Support Coordinator, as applicable, shall conduct a caregiver assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE as part of its face-to-face visit with new members in CHOICES Groups 2 and 3 (see Section A.2.9.6.2.5) and as part of its face-to-face intake visit for current members applying for CHOICES Groups 2 and 3 and as part of its face-to-face visit with new members in ECF CHOICES.

**25. Section A.2.9.6.6.2.2 shall be amended as follows:**

2.9.6.6.2.2 The CONTRACTOR shall ensure that Care Coordinators or Support Coordinators, as applicable, consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the plan of care or PCSP, as applicable. For members enrolled in ECF CHOICES Groups 7 or 8, person-centered planning processes shall be conducted by the Integrated Support Coordination Team as defined in this Contract.

**26. Section A.2.9.6.6.2.5.4 shall be amended as follows:**

2.9.6.6.2.5.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC or PCSP, as applicable, that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC or PCSP, as applicable, for the member (however, all schedule changes must be member-initiated); 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC or PCSP, as applicable, for the member; 3) changes in the member's current address and phone number(s) or the phone number(s) or address that will be used to log visits into the EVV system; 4) the end of a member's participation in MFP at the conclusion of his 365-day participation period; 5) for ECF CHOICES members, the completion of one employment service and the initiation of another one as the member progresses towards meeting individual employment goals established in the PCSP; or 6) instances as permitted pursuant to TennCare policies and protocols, including emergency circumstances

where the member's health and safety necessitate service initiation prior to member or representative signature. Documentation of such changes shall be maintained in the member's records, including an attachment listing all of the member's current LTSS providers. Each time a change in the member's LTSS provider(s) occur(s), the CONTRACTOR shall be responsible for circulating an amended attachment listing the current, updated LTSS provider list to all providers on the attachment within five (5) business days of any such update.

**27. Section A.2.9.6.8.14 shall be amended by amending Sections A.2.9.6.8.14 and A.2.9.6.8.14.2 as follows:**

2.9.6.8.14 The member's Care Coordinator shall also complete a PCSP that meets all criteria described in Section A.2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive assessment, completing a risk assessment, and making a final determination of cost neutrality. The member's Support Coordinator shall also complete a PCSP that meets all criteria described in Section A.2.9.6.6 for members in ECF CHOICES, including but not limited to completing a comprehensive assessment and shall identify risks and strategies to mitigate risks as part of the transition plan and PCSP. The PCSP shall be authorized prior to and initiated upon the member's transition to the community.

2.9.6.8.14.2 If a transitioning member is enrolled in CHOICES Group 2 or 3 or ECF CHOICES Groups 4, 5, or 6, but is receiving short-term nursing facility care, any CHOICES HCBS or ECF CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., for a CHOICES member, minor home modifications, adaptive equipment, or PERS installation; or for an ECF CHOICES member, minor home modifications, assistive technology, etc.) shall be completed while the member resides in the facility and billed as a Group 2 or Group 3 or ECF CHOICES service, as applicable. However, a member shall not be transitioned from CHOICES Group 1 into Group 2 or 3 or ECF CHOICES for receipt of short-term nursing facility services in order to provide these services. Short-term nursing facility care is available only to a CHOICES 2 or CHOICES 3 or ECF CHOICES Groups 4, 5, or 6 participant who was receiving home and community based services upon admission to the short-term nursing facility stay.

**28. Section A.2.9.6.9.2 shall be amended as follows:**

2.9.6.9.2 Prior to transition of any CHOICES Group 2 or 3 or ECF CHOICES member into a community-based residential alternative setting and the initiation of any community-based residential alternative services other than companion care (including assisted care living facility services, adult care homes, community living supports, community living supports-family model, and Intensive Behavioral Community Transition and Stabilization Services, as applicable), and prior to the transition of any CHOICES Group 2 or 3 or ECF CHOICES member to a new community-based residential alternative services provider, the Care Coordinator or Support Coordinator shall visit the residence where the member will live and shall, in accordance with protocols developed by TENNCARE, conduct an on-site assessment of the proposed community-based residential alternative setting to ensure that the living environment and living situation are appropriate and that the member's needs will be safely and effectively met, and that all necessary services and supports (including physical and behavioral health, medications, HCBS, and social supports needed to assure the member's health and safety) are in place.

**29. Section A.2.9.6.9.3 shall be amended as follows:**

2.9.6.9.3 Within the first twenty-four (24) hours of the transition of any CHOICES Group 2 or 3 or ECF CHOICES member into a community-based residential alternative setting and the initiation of

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any community-based residential alternative services other than companion care (including assisted care living facility services, adult care homes, community living supports, community living supports-family model, and Intensive Behavioral Community Transition and Stabilization Services, as applicable), and within the first twenty-four (24) hours of the transition of any CHOICES Group 2 or 3 or ECF CHOICES member to a new community-based residential alternative services provider, the Care Coordinator or Support Coordinator shall contact the member and within seven (7) days after the member has transitioned, the Care Coordinator or Support Coordinator shall visit the member in his/her new residence to confirm the member's satisfaction with the CBRA provider and services; that a medication reconciliation has been completed (as applicable) and that the member is receiving all necessary services and supports (including physical and behavioral health, medications, HCBS, and social supports needed to assure the member's health and safety), and any follow-up appointments have been arranged; that the plan of care or PCSP is being implemented; that the services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes; and that the member's needs are safely and effectively met. Such contacts may be completed by a member of the Transition Team who meets all of the requirements to be a Care Coordinator or Support Coordinator.

**30. Section A.2.9.6.10.2 shall be amended by amending Sections A.2.9.6.10.2, A.2.9.6.10.2.1, A.2.9.6.10.2.1.7, and A.2.9.6.10.2.1.17.2 as follows:**

2.9.6.10.2 *For Members in CHOICES Groups 2 and 3 and ECF CHOICES*

2.9.6.10.2.1 The CONTRACTOR shall provide for the following ongoing care coordination to CHOICES members in Groups 2 and 3 and ongoing support coordination to ECF CHOICES members, which shall comport with person centered planning requirements set forth in 42 C.F.R. § 441.301(c):

2.9.6.10.2.1.7 For members in CHOICES Group 3 or ECF CHOICES, determine whether the cost of CHOICES or ECF CHOICES HCBS, excluding minor home modifications for persons in CHOICES Group 3 and ECF CHOICES Group 4, will exceed the member's expenditure cap. The CONTRACTOR shall continuously monitor a member's expenditures and work with the member when he/she is approaching the limit including identifying non-Long Term Services and Supports services that will be provided when the limit has been met to prevent/delay the need for institutionalization. Each time the PCSP for a member in CHOICES Group 3 is updated, or the PCSP for ECF CHOICES members, the CONTRACTOR shall educate the member about the expenditure cap, as applicable;

2.9.6.10.2.1.17.2 Significant change in physical or behavioral health and/or functional status, including any change that results in the member's level of care and transition between CHOICES Groups or ECF CHOICES Groups, e.g., transitions from Group 2 to Group 3 or Group 3 to Group 2 or between ECF CHOICES Groups;

**31. Section A.2.9.6.10.2 shall be amended by amending Sections A.2.9.6.10.2.1.20, and by adding a new Section A.2.9.6.10.2.1.21 and renumbering the following section A.2.9.6.10.2.1.22 as follows:**

2.9.6.10.2.1.20 In the manner prescribed by TENNCARE, and in accordance with this Contract and TENNCARE policies and protocols pertaining thereto, facilitate transition to CHOICES Group 1, which shall include (but is not limited to) timely notification to TENNCARE;

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2.9.6.10.2.1.21 In the manner prescribed by TENNCARE, and in accordance with this Contract and TENNCARE policies and protocols pertaining thereto, facilitate transition planning when the CONTRACTOR has identified an ECF CHOICES Group 7 or 8 member who is appropriate to transition to another ECF CHOICES Group which shall include (but is not limited to) timely notification to TENNCARE; and

2.9.6.10.2.1.22 As part the annual reassessment and plan of care or PCSP review, as applicable, the Care Coordinator or Support Coordinator, as applicable, shall conduct, in a format prescribed by TENNCARE, an Individual Experience Assessment in order to ensure that the member's services and supports are provided in a manner that comports with the HCBS Setting Rule in 42 C.F.R. § 441.301(c)(4)-(5). The Care Coordinator or Support Coordinator, as applicable, shall be responsible for one hundred percent (100%) remediation of any instance in which the member's services do not comport with requirements set forth in the HCBS Settings Rule, and the CONTRACTOR shall analyze data from the Individual Experience Assessments by provider and by setting as part of its ongoing quality monitoring and re-credentialing processes.

**32. Section A.2.9.6.10.4 shall be amended by deleting and replacing Section A.2.9.6.10.4.1.1, and adding new Sections A.2.9.6.10.4.3.15 and A.2.9.6.10.4.3.16 as follows:**

2.9.6.10.4.1.1 While the CONTRACTOR may grant a member's request to conduct certain care coordination activities outside his or her place of residence, the CONTRACTOR is responsible for assessing the member's living environment in order to identify any modifications that may be needed and to identify and address, on an ongoing basis, any issues which may affect the member's health, safety and welfare. Repeated refusal by the member to allow the Care Coordinator to conduct visits in his or her home may, subject to review and approval by TENNCARE, constitute grounds for disenrollment from CHOICES Groups 2 or 3, or ECF CHOICES Groups, if the CONTRACTOR is unable to properly perform monitoring and other contracted functions and to confirm that the member's needs can be safely and effectively met in the home setting.

2.9.6.10.4.3.15 During at least the first month of enrollment in ECF CHOICES Group 7, the thirty (30) days leading up to any planned transition out of ECF CHOICES Group 7, and the thirty (30) days following transition out of ECF CHOICES Group 7 into another ECF CHOICES Group, members shall be contacted by their Integrated Support Coordination Team (ISCT) at least weekly either in person or by telephone or other form of audio/visual communication requested by and available to the member (i.e., the member's ISCT must complete each subsequent contact within seven (7) calendar days of the previous contact). A minimum of at least one weekly contact shall continue until IBFCTSS services are in place and for at least the first two weeks following the initiation of IBFCTSS services. These members shall be visited in their residence face-to-face by their ISCT at least monthly (i.e., the member's ISCT must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). Face-to-face and/or telephonic or other non-in-person contacts as requested by the member 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. The Support Coordinator and the Behavior Supports Director (or similarly qualified member of the ISCT) shall be present for all minimum face-to-face contacts.

2.9.6.10.4.3.16 During at least the first month of enrollment in ECF CHOICES Group 8, during the thirty (30) days leading up to any planned transition out of ECF CHOICES Group 8 and the thirty (30) days following transition out of ECF CHOICES Group 8 into another ECF CHOICES

Group, members shall be contacted by their ISCT at least weekly either in person or by telephone or other form of audio/visual communication requested by and available to the member (i.e., the member's ISCT must complete each subsequent contact within thirty (30) calendar days of the previous contact). A minimum of at least one weekly contact shall continue until IBCTSS are in place and for at least the first two weeks following the initiation of IBCTSS. These members shall be visited in their residence face-to-face by their ISCT at least monthly (i.e., the member's ISCT must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). Face-to-face and/or telephonic or other non-in-person contacts as requested by the member 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. The Support Coordinator and the Behavior Supports Director (or similarly qualified member of the ISCT) shall be present for all minimum face-to-face contacts.

**33. Section A.2.9.6.12.9.6 shall be amended by adding new 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 five (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 five (6).

**34. Section A.2.9.6.12.9 shall be amended by deleting Sections A.2.9.6.12.9.7, A.2.9.6.12.9.7.1, A.2.9.6.12.9.7.2, A.2.9.6.12.9.8, A.2.9.6.12.9.8.1, and A.2.9.6.12.9.8.2 including any references thereto.**

**35. Section A.2.9.6.12.11 shall be amended as follows:**

2.9.6.12.11 Upon request, the CONTRACTOR shall provide to TENNCARE documentation of such monitoring, including an itemized list by Care Coordinator/Support Coordinator of the total number of members assigned, and the number of Group 1 members (including members in transition and children under age 21), Group 2, Group 3 and ECF CHOICES members that comprise each Care Coordinator/Support Coordinator's caseload.

**36. Section A.2.11.2 shall be amended by adding a new Section A.2.11.2.8 as follows:**

2.11.2.8 The CONTRACTOR agrees to implement Primary Care Transformation strategies, inclusive of PCMH (comprehensive primary care program) and Tennessee Health Link (integrated care coordination for members with the highest behavior health needs), consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE.

**37. Section A.2.11 shall be amended by adding a new Section A.2.11.4 as follows and renumbering the remaining Section accordingly, including any references thereto.**

**2.11.4 Medication Assisted Treatment (MAT) Network**

2.11.4.1 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 as described below.

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- 2.11.4.1.1 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.
  - 2.11.4.1.1.1 The CONTRACTOR shall conduct at minimum one (1) in-person check-in with each contracted MAT provider per calendar year. The CONTRACTOR must have the appropriate representation to discuss the following with the provider in-person:
    - 2.11.4.1.1.1.1 Billing or processing questions;
    - 2.11.4.1.1.1.2 Provide education (programmatic and clinical);
    - 2.11.4.1.1.1.3 Quality metrics;
    - 2.11.4.1.1.1.4 Program description and opportunities for additional supports.
  - 2.11.4.1.1.2 The CONTRACTOR shall conduct one (1) audit meeting 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 MCOs shall review a minimum of ten (10) member charts.
    - 2.11.4.1.1.2.1 The CONTRACTORS may collaborate to allow a provider to only be audited by one CONTRACTOR during a calendar year. If the CONTRACTORS decide to partner, this will count towards the requirements for all CONTRACTORS in the partnership.
  - 2.11.4.1.1.3 The CONTRACTOR shall conduct at minimum one (1) virtual education session for all contracted MAT providers per calendar year. The virtual education session will be for MAT providers and staff to receive additional training, education, or necessary general updates to the MAT network requirements. All topics for the virtual education sessions will be shared with TENNCARE in advance of the meeting and approved by TENNCARE.
    - 2.11.4.1.1.3.1 The MCOs may collaborate to provide a single virtual education session for providers. If the MCOs decide to partner, this will count towards the requirements for all MCOs in the partnership.
    - 2.11.4.1.1.3.2 The CONTRACTOR shall ensure the recording of the virtual education session and make the recording available to contracted MAT providers for future viewings.
- 2.11.4.1.2 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.
  - 2.11.4.1.2.1 Each CONTRACTOR shall conduct one (1) in-person meeting per contracted MAT provider per calendar year to function as a check-in and audit.
  - 2.11.4.1.2.2 The CONTRACTOR shall conduct one (1) virtual education session per calendar year for all contracted MAT providers.
    - 2.11.4.1.2.2.1 The MCOs may collaborate to provide a single virtual education session for providers. If the MCOs decide to partner, this will count towards the requirements for all MCOs in the partnership.

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2.11.4.1.2.2.2 The CONTRACTOR shall ensure the recording of the virtual education session and make the recording available to contracted MAT providers for future viewings.

2.11.4.1.3 The CONTRACTOR shall distribute quarterly MAT Network Quality Metrics Reports to all contracted MAT providers on a 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.

**38. Section A.2.12.10 shall be amended by adding a new Section A.2.12.10.21as follows:**

2.12.10.21 Require that, in the event the contract is terminated because of a change of ownership, the CONTRACTOR shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

**39. Section A.2.12 shall be amended by adding the new Section A.2.12.23 as follows:**

A.2.12.23 All provider agreements between the CONTRACTOR and a home health agency (HHA) shall require the HHA to comply with the federal regulations delineating the conditions of participation that HHAs must meet in order to participate in the Medicaid program. Each provider agreement must contain a general provision to that effect.

2.12.23.1 Each provider agreement must specify that the contracted HHA supply each enrollee with the following:

2.12.23.1.1 Written and verbal notice of the enrollee's rights and responsibilities as a home health patient as required under 42 CFR §484.50(a);

2.12.23.1.2 Written and verbal notice of the HHA's policy for transfer and discharge as required under 42 CFR §484.50(d), including an explanation in plain language that disruptive, abusive, or uncooperative behaviors could give rise to a "discharge for cause," and the requirements that must be satisfied by the HHA in order for transfer or a discharge to be effectuated;

2.12.23.1.3 Written and verbal notice of the HHA's obligation to accept complaints made by the enrollee about the care that is (or fails to be) furnished, and of the HHA's obligation to investigate, document, and resolve these enrollee complaints (as well as complaints of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, or injuries of unknown source, or misappropriation of the enrollee's property by anyone furnishing care on behalf of the HHA) as required under 42 CFR §484.50(e).

2.12.23.1.4 The HHA must explain to the enrollee the scope of the home health services that the enrollee will be receiving. Afterwards, the HHA must obtain the signature of the enrollee verifying that an HHA staff member has explained the scope of services to the enrollee. Likewise, the HHA must obtain, as required under 42 C.F.R. § 484.50(a)(2), the enrollee's or the legal representative's signature confirming that they received written notice of the enrollee's rights and responsibilities as required by Section A.2.12.23.1.1. The HHA must maintain all signature(s) in their record of the enrollee.

2.12.23.1.5 The HHA must develop a back-up plan for each enrollee to be implemented during missed visits, as defined by Section A.2.15.9.1, or when otherwise necessary.

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- 2.12.23.1.6 When the HHA is notified before a missed visit occurs or as it is occurring, the HHA must contact the enrollee and implement the back-up plan or offer a suitable alternative service. The HHA must report all missed visits to the CONTRACTOR in writing within three calendar days of the missed visit. This report must be submitted on a CONTRACTOR-approved form, which captures all of the information the CONTRACTOR requires, including, but not limited to, the following: the identity of the enrollee; the type of service involved; the date of the missed visit; the cause(s); and, what corrective action was taken to mitigate the cause(s) of the missed visit. The HHA must ensure that the staff member enters notes about the circumstances of a missed visit in every instance in which notes are possible.
- 2.12.23.1.7 When a conflict arises between an enrollee and an assigned HHA staff member, or when an enrollee refuses to allow an assigned staff member to begin or to complete their assigned visit, the staff member will immediately notify the HHA. Once notified, the HHA will contact the enrollee and offer to either (1) implement the existing back-up plan or (2) staff the care with a qualified alternative staff member. In every instance, the HHA must record these missed visits, as described above, and timely submit them to the CONTRACTOR. All of the aforementioned facts should be included in the reports with as much written explanation as possible regarding the causes and factors contributing to the conflict. If additional conflicts arise between the enrollee and the HHA or alternative staff member (for example, if an enrollee refuses to admit the alternative staff member into enrollee's home), the HHA must notify the CONTRACTOR and must continue making reasonable efforts to staff the approved care with qualified alternative staff members until the HHA, in its discretion, plans to discharge the enrollee for cause. At that point, the HHA must notify the CONTRACTOR of its decision to discharge or transfer the enrollee.

**40. Section A.2.13.1.9 shall be deleted and replaced as follows, updating any existing references accordingly.**

- 2.13.1.9 The CONTRACTOR agrees to implement Episodes of Care (retrospective episode based reimbursement for specialty and acute care) and Primary Care Transformation strategies, inclusive of PCMH (comprehensive primary care program) and Tennessee Health Link (integrated care coordination for members with the highest behavior health needs), consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes:
  - 2.13.1.9.1 Using a retrospective process to administer value-based outcome payments for the initiative's payment reform strategies that is aligned with the models designed by TENNCARE.
  - 2.13.1.9.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode, and the definition of quality measures for the initiative's payment reform strategies.
  - 2.13.1.9.3 Implementation of payment reform strategies and improvements at a pace dictated by the State. This includes actively participating in episodes-related stakeholder conversations.
  - 2.13.1.9.4 Implementation of aligned TennCare PCMH strategy shall include at least thirty-four percent (34%) of the CONTRACTOR's TennCare population beginning January 1, 2019 and at least thirty-five percent (35%) of the population beginning January 1, 2020.
    - 2.13.1.9.4.1 TENNCARE shall monitor the CONTRACTOR's compliance in accordance with the following:
      - 2.13.1.9.4.1.1 The CONTRACTOR shall submit separate PCMH membership counts for members attributed to groups that are anticipated to sign TennCare PCMH contracts as well as members attributed to groups who have executed TennCare PCMH contracts with the CONTRACTOR. PCMH membership counts shall be submitted in accordance with Section 2.30.4.7.

Amendment 9 (cont.)

2.13.1.9.4.1.2 The percentage of compliance shall be calculated using the following formulas:

Target Date	Formula
July 31	CONTRACTOR's total TennCare PCMH membership as of June 30 from <i>anticipated</i> PCMH TINs for January 1 of following year / CONTRACTOR's total TennCare members with an assigned PCP, excluding non-aligned dual eligible members as of June 30
January 31	CONTRACTOR's total TennCare PCMH membership as of January 1 from <i>actual</i> PCMH TINs for January 1 of actual year / CONTRACTOR's total TennCare members with an assigned PCP, excluding non-aligned dual eligible members as of January 1

2.13.1.9.4.1.3 TENNCARE shall monitor the CONTRACTOR's progress in accordance with the following timeline:

Target Date	Benchmark
July 31, 2018	TENNCARE shall verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2019
January 31, 2019	TENNCARE shall verify that the CONTRACTOR is meeting the PCMH membership requirement for 2019
July 31, 2019	TENNCARE shall verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2020 <u>AND</u> shall verify that the CONTRACTOR is still meeting the PCMH membership requirement for 2019
January 31, 2020	TENNCARE shall verify that the CONTRACTOR is meeting the PCMH membership requirement for 2020
July 31, 2020	TENNCARE shall verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2021 <u>AND</u> shall verify that the CONTRACTOR is still meeting the PCMH membership requirement for 2020

2.13.1.9.4.1.4 Failure to meet and maintain the percentage benchmarks described above may result in liquidated damages described in Section E.29.

2.13.1.9.5 Participate in a State-led process to design, launch and refine the initiative's payment reform strategies, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee for the development of new episodes.

2.13.1.9.6 The CONTRACTOR shall submit an annual *Provider Engagement Plan* and quarterly *Provider Engagement Tracker* detailing information and communication plans with the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care providers in accordance with Sections A.2.30.4.6.1 and A.2.30.4.6.2.

2.13.1.9.7 Delivering performance reports for the initiative's payment reform strategies with the same appearance and content as those designed by the State/Payer Coalition.

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- 2.13.1.9.8 The CONTRACTOR shall update cost and quality thresholds annually for all episodes in performance. The updated cost and quality thresholds shall be included in the Episodes of Care Performance Reports.
- 2.13.1.9.9 The CONTRACTOR shall submit documents related to Payment Reform Initiatives (e.g., data analytics requests) to TENNCARE in a timely manner as requested by the state.
- 2.13.1.10 The CONTRACTOR shall implement State Budget Reductions and Payment Reform Initiatives, including retrospective episode based reimbursement, as described by TENNCARE. The CONTRACTOR's failure to implement State Budget Reductions and/or Payment Reform Initiatives as described by TENNCARE may, at the discretion of TENNCARE, result in the CONTRACTOR forfeiting savings that would have been realized based on the timely implementation, including the forfeiture of recoupment from providers.
- 2.13.1.10.1 The CONTRACTOR shall not retroactively adjust payments made to an out of network provider due to budget reductions unless approved by TENNCARE.

**41. Section A.2.13.3.3 shall be amended as follows:**

- 2.13.3.3 . The CONTRACTOR shall be responsible for monitoring the member's continued need for and receipt of skilled and/or rehabilitative services in a NF only when approval of NF LOC is conditioned on the receipt of such services, and in such case, when skilled and/or rehabilitative services are no longer medically necessary, shall submit information needed by TENNCARE to reevaluate whether the member continues to meet level of care for nursing facility services (see also Section A.2.14.1.14).

**42. Sections A.2.14.1.14.1 and A.2.14.5.2 shall be amended as follows:**

- 2.14.1.14.1 The CONTRACTOR shall be responsible for monitoring the member's continued need for and receipt of skilled and/or rehabilitative services in a NF only when approval of NF LOC is conditioned on the receipt of such services, and in such case, when skilled and/or rehabilitative services are no longer medically necessary, shall submit information needed by TENNCARE to reevaluate the member's level of care (i.e., reimbursement) for nursing facility services (see also Section A.2.14.1.14).
- 2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section A.2.14.1.14)..

**43. Section A.2.14.3.5 through A.2.14.3.5.3 and Section A.2.30.11.5 shall be deleted and replaced as follows:**

2.14.3.5 Referral Provider Listing

2.14.3.5.1 The CONTRACTOR shall provide all PCPs with information on how to access a current listing of referral providers, including behavioral health providers, as well as the right to request a hard copy at least thirty (30) calendar days prior to the start date of operations. Thereafter the CONTRACTOR shall provide notification to PCPs regarding how to access and request a hard copy of an updated version of the listing on a quarterly basis. The CONTRACTOR shall maintain an updated electronic, web-accessible version of the referral provider listing.

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section A.2.17.8.

2.14.3.5.3 As required in Section A.2.30.11.5, the CONTRACTOR shall submit to TENNCARE a copy of the notification regarding the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.30.11.5 The CONTRACTOR shall submit a copy of the notification regarding the Referral Provider Listing (see Section A.2.14.3.5), a data file of the provider information used to create the listing, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the notices to providers, the date sent, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section A.2.14.3.5.

**44. Section A.2.15.6.3 shall be deleted in its entirety including any references thereto and Section A.2.15.5.1 shall be amended as follows:**

2.15.5.1 TENNCARE shall require the CONTRACTOR to be NCQA accredited or obtain NCQA accreditation within the timelines specified below. Health plans applying for NCQA accreditation must notify NCQA of the accreditation option they choose. The CONTRACTOR shall choose the first evaluation option which will require the CONTRACTOR to notify NCQA of this option six (6) months prior to submission of HEDIS data. Health Plans providing LTSS shall obtain NCQA Long-Term Services and Supports Distinction by December 31, 2019.

**45. Section A.2.15.7.3 shall be amended by deleting and replacing Section A.2.15.7.3.2 and adding new Sections A.2.15.7.3.3 and A.2.15.7.3.4 as follows:**

2.15.7.3.2 Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) business hours of the CONTRACTOR 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.

2.15.7.3.3 The CONTRACTOR shall, as part of its critical incident management system, track, review and analyze critical incident data that takes into consideration all incidents occurring for members supported by an agency, that occur during the provision of HH services, including the identification of trends and patterns, opportunities for improvement, and actions and strategies the CONTRACTOR will take to reduce the occurrence of incidents and improve the quality of HH services received.

2.15.7.3.4 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of HH services.

**46. Section A.2.15.7.6.3 shall be amended by amending Sections A.2.15.7.6.3.1.5 and A.2.15.7.6.3.2.8 as follows:**

2.15.7.6.3.1.5 Vehicle accident while transporting person resulting in injury or a moving violation with significant risk of harm (e.g., reckless driving or driving under the influence, ;

2.15.7.6.3.2.8 The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued at \$1,000 or less, i.e., less than the threshold for misappropriation.

**47. Section A.2.15 shall be amended by adding a new Section A.2.15.9 as follows:**

**A.2.15.9 Missed Visits of Home Health Services**

2.15.9.1 “Missed visit,” as used herein, refers to a period of one or more hours that a staff member of an HHA does not furnish the home health service that an enrollee is authorized to receive and which has been implemented. A missed visit may be due to exigent circumstances beyond any party’s control. It may also be due to a fault of the HHA, the staff member, or the CONTRACTOR. It may also be due to a fault of the enrollee. For example, the enrollee refuses to allow the staff member to enter the home or to remain there after beginning work; the staff member suspects or witnesses unlawful activity in the home; or, the environment in the enrollee’s home is such that the staff member fears for their personal safety.

2.15.9.2 The CONTRACTOR shall collect all missed-visit reports delivered to them by the HHAs and monitor them. As a general practice, the CONTRACTOR shall identify negative trends with regard to particular HHAs or enrollees. The CONTRACTOR shall contact the HHAs and attempt to resolve such negative trends. In its discretion, the CONTRACTOR may contact enrollees in order to remediate such negative trends.

2.15.9.3 The CONTRACTOR shall respond to all inquiries from TENNCARE regarding potential missed visits by submitting timely documentation showing the dates and times of any missed visits, the name of the HHA involved, and the cost of each visit had it been provided, as well as any other information reasonably requested by TENNCARE.

2.15.9.4 Upon monitoring the missed-visit reports or upon being notified by an HHA of an enrollee’s refusal of two (2) or more staff members, the CONTRACTOR shall contact the HHA and the enrollee to attempt a resolution while the HHA remains willing and able to provide services to the enrollee. This may include the CONTRACTOR scheduling a meeting between a member of its management, the enrollee, and HHA personnel. The CONTRACTOR shall document every action taken.

2.15.9.5 If the enrollee has refused two (2) or more staff members, the CONTRACTOR shall assign a case-manager to the enrollee if one is not already assigned. The CONTRACTOR shall also contact the primary care provider to advise him or her of the enrollee’s pattern of refusing the authorized services

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and to discuss a possible solution. The conversation, and any decisions made, shall be documented in the CONTRACTOR'S record for the enrollee.

- 2.15.9.6 If the HHA plans to discharge the enrollee for cause, the CONTRACTOR shall send the enrollee a letter informing them that the HHA will no longer be providing their care as of a certain date, and that they have either found or are searching for another HHA to replace it. The CONTRACTOR, however, should only seek the services from in-network HHAs. The CONTRACTOR shall also send a delay notice to the enrollee if a delay occurs to the enrollee receiving the service from the new provider.
- 2.15.9.7 If the enrollee continues to refuse staff members from the newly selected HHA, the CONTRACTOR shall again follow the protocol.
- 2.15.9.8 If after the CONTRACTOR follows the protocol in Section A.2.15.9.5 twice and the situation is not then resolved, the CONTRACTOR, at its discretion, shall make a reasonable number of attempts (if any) to arrange for further in-network HHAs to provide the enrollee's authorized care taking into account the number of HHAs available in the enrollee's county and/or adjacent counties.
- 2.15.9.9 When all reasonable attempts have been exhausted, the CONTRACTOR shall move to terminate the enrollee's home health service. When the CONTRACTOR decides to terminate the enrollee's care, it shall, if it has not already done so, collect all of the relevant missed-visit reports. The CONTRACTOR must then, if it has not already done so, make a single record consisting of a list of the names of the agencies used and how many staff members from each agency were refused by the enrollee. The CONTRACTOR shall also offer a covered medically necessary alternative, such as facility-based care, to the enrollee.
- 2.15.9.10 Once these steps are completed, the CONTRACTOR shall issue a Notice of Adverse Benefit Determination, citing Tenn. Comp. R. & Regs. ("Rule") 1200-13-16-.05(1)(c), and (5) (or other rule(s) as TENNCARE may direct), and the reason for the termination. The notice shall also state the covered medically necessary alternative, if any. The CONTRACTOR shall forward a copy of that notice to TENNCARE.

**48. Section A.2.17.7.3.23 shall be amended as follows:**

- 2.17.7.3.23 Information for members in Groups 2 and 3 and ECF CHOICES regarding self-direction of health care tasks.

**49. 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; and documentation requirements for CHOICES and ECF CHOICES HCBS providers;

**50. Section A.2.18.7 shall be amended by deleting and replacing Section A.2.18.7.4 and deleting Section A.2.18.7.5, including any references thereto.**

2.18.7.4 The CONTRACTOR shall conduct an annual survey of providers, based on Tax Identification Number, who furnish physical health services, behavioral health services, nursing facility services, CHOICES HCBS, and/or ECF-CHOICES HCBS. All providers or a statistically representative sample of providers shall be surveyed. The CONTRACTOR shall include questions specified by TENNCARE to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, utilization management processes, including medical reviews, and overall satisfaction with the CONTRACTOR. The CONTRACTOR shall submit the survey tool(s) for TENNCARE review at least thirty (30) days prior to use of the survey tool(s). The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section A.2.30.13.3. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey and provide an update on actions taken in the previous year to improve provider satisfaction. The survey shall be structured so that results are separately reported for physical health providers; behavioral health providers; CHOICES (nursing facilities and HCBS) providers; and ECF-CHOICES HCBS providers.

**51. Section A.2.18 shall be amended adding new Sections A.2.18.11, A.2.18.11.1, and A.2.18.11.2 as follows:**

**2.18.11 Beneficiary Support System**

2.18.11.1 The CONTRACTOR shall, as required by TENNCARE, collaborate with TENNCARE's beneficiary support system contractor for the purpose of addressing member grievances and appeals.

2.18.11.2 The CONTRACTOR shall, as requested by TENNCARE, train TENNCARE's beneficiary support system contractor on the CONTRACTOR's process for addressing member grievances and appeals.

**52. Section A.2.20.1 shall be amended by adding a new Section A.2.20.1.13 as follows:**

2.20.1.13 The CONTRACTOR shall comply with all written direction provided by TennCare OPI regarding fraud and abuse investigations, overpayments, and any other program integrity related activities and reporting.

**53. Section A.2.20.2.4.1 shall be amended by deleting and replacing the word "opened" with the word "received" 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 MFCU;

**54. Section A.2.20.2.7 through A.2.20.2.7.3 shall be amended as follows:**

- 2.20.2.7 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed provider fraud and abuse, unless it is determined that the provider is currently under investigation or litigation by the State or federal government. If the provider is determined to be under investigation or litigation by the State or federal government, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims, without prior written approval from the State or federal government:
- 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.

**55. Section A.2.20.2.15 through A.2.20.2.15.3 shall be amended as follows:**

- 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.

**56. Sections A.2.20.3.1 and A.2.20.3.8 shall be deleted and replaced as follows:**

- 2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to TennCare OPI within ninety (90) calendar days of Contract execution and 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.
- 2.20.3.8 The CONTRACTOR shall have provisions in its Compliance Plan regarding prompt terminations of inactive providers due to inactivity in the past 12 months, unless TENNCARE provides prior approval for a provider type to remain contracted or as otherwise required by TENNCARE.

**57. Section A.2.22 shall be amended to include a new Section A.2.22.4.12 as follows:**

Amendment 9 (cont.)

2.22.4.12 The CONTRACTOR shall not require, as a condition to reimbursement, a Medicare Explanation of Benefits for nursing facility claims, nor shall the CONTRACTOR delay such reimbursement on the basis that third party liability must be captured and paid. However, the CONTRACTOR shall seek any applicable third party liability that is applicable and recover those amounts.

**58. Section A.2.22.8.1 through A.2.22.8.1.8 shall be deleted and replaced as follows:**

2.22.8.1 The CONTRACTOR shall perform front end system edits, prior to entering the claims adjudication system, including but not limited to:

2.22.8.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

2.22.8.1.2 Third party liability (TPL);

2.22.8.1.3 Medical necessity (e.g., appropriate age/sex for procedure);

2.22.8.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;

2.22.8.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;

2.22.8.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;

2.22.8.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted, including requirements related to public health nurses as described in Section A.2.13.7.2;

2.22.8.1.8 Benefit limits: the system shall ensure that benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid and whether CHOICES or ECF CHOICES HCBS that exceed a benefit limit were approved as a cost effective alternative; and

2.22.8.1.9 HIPAA compliancy validation.

**59. Section A.2.23.4.4 shall be amended by adding a new Section A.2.23.4.4.10 as follows:**

2.23.4.4.10 The CONTRACTOR shall not implement imitations of TENNCARE's Custom SNIP 7 Encounter Edits Listing or likewise use the TennCare Edifecs Ramp Manager tool for the purpose of preventing submission of post adjudicated encounter production data to TENNCARE. It is permissible for the CONTRACTOR to implement imitations of TENNCARE's Custom SNIP 7 Encounter Edits Listing prior to claim adjudication.

**60. Section A.2.23.5 shall be amended by adding new Sections A.2.23.5.3 and A.2.23.5.4 as follows and renumber the remaining Sections accordingly, including any references thereto.**

2.23.5.3 The CONTRACTOR shall submit daily, inbound 834 enrollment files to TENNCARE.

2.23.5.4 The CONTRACTOR shall report address changes, other TPL resource and PCP assignments for their members in the daily 834 inbound files within twenty-four (24) hours or within the next 834 inbound file submission to TENNCARE. If the CONTRACTOR has reason to believe they may not meet this

requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

**61. TENNCARE Section A.2.23.13.1 shall be deleted and replaced as follows:**

2.23.13.1 Within five (5) business days of receipt of notice from TENNCARE of the occurrence of a problem with the provision and/or intake of an encounter or outbound 834 enrollment file or submission of an inbound 834 file, the CONTRACTOR shall provide TENNCARE with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the CONTRACTOR has addressed or will address the immediate problem and how the CONTRACTOR shall prevent the problem from recurring. In the event that the CONTRACTOR fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TENNCARE, fails to submit a corrective action plan may assess liquidated damages as specified in Section E.29.2. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, including possible forfeiture of the withhold (see Section C.3.9), or be considered a breach of the Contract.

**62. Section A.2.24.2 shall be deleted and replaced as follows:**

**A.2.24.2 Annual Behavioral Health Engagement Plan**

The CONTRACTOR shall submit an Annual Behavioral Health Engagement Plan, in a format specified by TENNCARE, which describes the CONTRACTOR's plan for engaging TennCare members, family representatives and behavioral health providers for the purpose of receiving input and advice regarding all aspects of behavioral health services according to the following requirements:

- 2.24.2.1 The CONTRACTOR's engagement activities shall involve at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include individuals and/or families of those who may meet the clinical criteria of a priority enrollee;
- 2.24.2.2 There shall be geographic diversity;
- 2.24.2.3 There shall be cultural and racial diversity;
- 2.24.2.4 There shall be representation by behavioral health providers, Certified Peer Recovery Specialists and/or Certified Family Support Specialists and consumers (or family members of consumers) of substance abuse services, and the CONTRACTOR's Behavioral Health Consumer Advocates;
- 2.24.2.5 At a minimum, input shall include policy development, planning for services, service evaluation, and member, family member and provider education;
- 2.24.2.6 Whenever the CONTRACTOR's engagement plan involves travel, the CONTRACTOR shall pay travel costs for consumers and family representatives;
- 2.24.2.7 The CONTRACTOR shall provide education and training to ensure consumers, family representatives and providers have sufficient information and understanding of the CONTRACTOR's engagement activities to ensure active participation and involvement.

2.24.2.8 Upon request, the CONTRACTOR shall provide a report on the engagement activities outlined in the CONTRACTOR's annual engagement plan in a format specified by TENNCARE.

**63. Section A.2.24.3 shall be amended by adding a new Section A.2.24.3.10 as follows:**

2.24.3.10 In addition, the CONTRACTOR shall work with its CHOICES advisory group to convene community forums for individuals and families and for CHOICES providers in each Grand Region on at least an annual basis in order to provide member, family and provider education, and to gather input and advice regarding the CONTRACTOR's CHOICES program, policies and operation.

**64. Section A.2.25.6 shall be deleted and replaced as follows:**

**A.2.25.6 Audit Requirements**

2.25.6.1 The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section A.2.20 of this Contract. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury personnel during the Contract period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Contract period, these records shall be available at the CONTRACTOR's chosen location in Tennessee subject to the written approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE in writing. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section A.2.23.2 (Data and Document Management Requirements), A.2.23.3 (System and Data Integration Requirements), or A.2.23.6 (Security and Access Management Requirements) of this Contract.

2.25.6.2 The CONTRACTOR shall comply with Centers for Medicare & Medicaid Services (CMS) mandated Payment Error Rate Measurement (PERM) audits which occur every three (3) years on a fiscal year basis from July 1<sup>st</sup> through June 30<sup>th</sup>. All deadlines must be met as communicated from both CMS and TENNCARE.

2.25.6.2.1 The CONTRACTOR shall provide assistance with the state to obtain all requested and/or missing medical records from contracted providers, selected among the random audit sample, within the requested timeframe given by the CMS Review Contractor to prevent an audit finding.

2.25.6.2.2 The CONTRACTOR shall provide written procedures annually on June 1<sup>st</sup> to TENNCARE for review and approval detailing the internal and external procedures and activities that must occur in

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preparation to generate the PERM claims, provider, and recipient universe files, data dictionary, file layout, and transmission coversheets quarterly within each PERM cycle.

2.25.6.2.3 The CONTRACTOR shall implement a Quality Control component which must be documented in the CONTRACTOR's written procedures, to review all requested file layouts, data dictionaries, transmission coversheets, PERM claims, provider, and recipient universe files prior to submission to the state.

**65. Section A.2.29.1.3 shall be amended by deleting and replacing Sections A.2.29.1.3.5, A.2.29.1.3.42.1, A.2.29.1.9, adding a new Section A.2.29.1.3.6 and renumbering the remaining Section accordingly, including any references thereto.**

2.29.1.3.5 A full-time senior executive dedicated exclusively to the TennCare program who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. Experience directing behavioral health programs and services for special populations, including individuals with intellectual or developmental disabilities, shall be preferred, but not required. This person shall serve as the Behavioral Health Medical Director and shall oversee and be responsible for all behavioral health activities, including behavioral health services provided to individuals receiving LTSS and the populations served in LTSS programs (e.g., frail elderly, adults with physical disabilities, and people of any age with intellectual or developmental disabilities). The Behavioral Health Medical Director shall be responsible for the implementation of Behavior Crisis Prevention, Intervention and Stabilization Services as described in Section A.2.7.2.8.4 of this Contract; all behavioral health activities pertaining to the operation of LTSS programs and services, including the management and coordination of behavioral health needs; and the integration and coordination of behavioral health services for members receiving LTSS and comparable populations. The Behavioral Health Medical Director shall be responsible for working with the LTSS Medical Director (see A.2.29.1.3.4) and the Behavior Supports Director (see A.2.29.1.3.6) to ensure the integration of physical and behavioral health services and supports and LTSS, as applicable, for individuals in each of these populations, and to oversee the CONTRACTOR's quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations;

2.29.1.3.6 A full-time senior executive who works primarily with the TennCare program and is dedicated to Tennessee's line of business. The individual must have a Master's degree in a health care related profession and at least five (5) years of combined experience in mental health and substance abuse service. Experience directing behavioral health programs and services for special populations, including individuals with intellectual or developmental disabilities, is required. This person shall be responsible for all behavioral health program operations and requirements;

2.29.1.3.42.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES.

2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, Behavioral Health senior executive, Behavior Supports Director, CHOICES senior executive, ECF CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, ECF CHOICES provider claims education and assistance staff, UM staff, appeals staff, Population Health Complex Case Management staff, care coordination leadership and staff, support coordination leadership and staff, CHOICES and ECF CHOICES lead trainers, consumer advocates, employment services director,

housing specialist, and TennCare Kids staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE. Staff assigned to and working in a geographic area of the state, but living in a border state do not require prior approval from TENNCARE as long as their primary work under this Contract is performed in-state.

**66. Section A.2.30.4 shall be deleted and replaced as follows, including any references thereto.**

**A.2.30.4 Specialized Service Reports**

- 2.30.4.1 The CONTRACTOR shall submit a quarterly 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); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18).
- 2.30.4.2 The CONTRACTOR shall submit a quarterly Post-Discharge Services Report that provides information on Post-Discharge services appointments. The minimum data elements required are identified in Attachment IX, Exhibit B.
- 2.30.4.3 The CONTRACTOR shall submit a quarterly Behavioral Crisis Prevention, Intervention, and Stabilization Services for Individuals with Intellectual or Developmental Disabilities (I/DD) Report including the data elements described by TENNCARE. Specified data elements shall be reported for each individual provider as described in the template provided by TENNCARE.
- 2.30.4.4 The CONTRACTOR shall submit a TennCare Kids Quarterly Outreach Activities Report which shall be in a format designated by TENNCARE and shall include a listing of related and non-related TennCare Kids events.
- 2.30.4.5 The CONTRACTOR shall submit a *Monthly EPSDT Claims Report*, which shall include the number of EPSDT screening claims processed by region for the service dates beginning with the current federal fiscal year (October 1) through the last day of the current month. This report shall be due by the 20th day after the end of the reporting month.
- 2.30.4.6 The CONTRACTOR shall submit Payment Reform Engagement, Education and Outreach Reports as follows:
  - 2.30.4.6.1 The CONTRACTOR shall submit a single 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 Provider Engagement Plan shall be effective as of January 1st of the next calendar year.
    - 2.30.4.6.1.1 The Provider Engagement Plan 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

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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).

- 2.30.4.5.1.2 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.
- 2.30.4.6.2 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.2.30.10.7.1 to A.2.30.10.7.3.
- 2.30.4.6.2.1 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.
- 2.30.4.6.2.2 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.
- 2.30.4.6.2.3 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.
- 2.30.4.6.3 The CONTRACTOR shall submit a quarterly *Provider Outreach Communication Report* that shall track and include all in-person visits, calls, mailings, and all other communications for THL, PCMH and Episodes of Care.
- 2.30.4.7 The CONTRACTOR shall submit Episodes of Care Reports as follows:
  - 2.30.4.7.1 The CONTRACTOR shall create and release quarterly *Episodes of Care Performance Reports* (including the PAP list) to TENNCARE. The CONTRACTOR shall also release quarterly Episodes of Care Performance Reports to providers via the CONTRACTOR's portal. This includes making all required updates to the reports requested by the state to ensure compliance with Sections A.2.13.1.9.7 and A.2.13.1.9.8.
- 2.30.4.8 The CONTRACTOR shall submit PCMH Reports as follows:
  - 2.30.4.8.1 The CONTRACTOR shall submit an annual *PCMH Membership/Anticipated PCMH Contract Report*. The report shall include PCMH membership counts as of June 30 of each year for members attributed to groups that are anticipated to sign TennCare PCMH contracts effective

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January 1 of the following year. PCMH membership shall exclude non-aligned dual eligible members. This PCMH Membership/Anticipated PCMH Contract Report is due to TENNCARE no later than July 31 of each year.

- 2.30.4.8.2 The CONTRACTOR shall submit an annual *PCMH Membership/Contracted PCMH Report*. The report shall include PCMH membership counts as of January 1 of each year for all members with an attributed PCP that is associated with a TIN contracted in the TennCare PCMH program. PCMH membership shall exclude non-aligned dual eligible members. This PCMH Membership/Contracted PCMH Report is due to TENNCARE no later than January 31 of each year.
- 2.30.4.8.3 The CONTRACTOR shall submit an annual *PCMH Risk Band Values for Activity Payments (pmpms) Report* for the upcoming performance year. The PCMH list of risk band values for activity payments Report will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than September 30 of each year.
- 2.30.4.8.4 The CONTRACTOR shall submit an annual *PCMH Practice Type Designations Report* assigned to participating PMCHs based upon the proportion of adult and/or children attributed as of June 30 of the year before the performance period begins. The PCMH practice type designations Report will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than September 30 of each year.
- 2.30.4.8.5 The CONTRACTOR shall submit a Semi-Annual *PCMH Heat Maps Performance Tracker Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than June 15 and December 15 of each year.
- 2.30.4.8.6 The CONTRACTOR shall submit Semi-Annually, a *PCMH Quality Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than March 15 and September 15 of each year.
- 2.30.4.8.7 The CONTRACTOR shall submit quarterly, *PCMH Provider Sample Reports* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than February 15th, May 15th, August 15, and November 15th of each year.
- 2.30.4.8.8 The CONTRACTOR shall submit quarterly, *PCMH Provider Reports* to participating PCMHs. The reports will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than February 28th, May 31th, August 31, and November 30th of each year.
- 2.30.4.8.9 The CONTRACTOR shall submit a quarterly *PCMH Outcome Payment Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than February 28th, May 31th, August 31, and November 30th of each year.
- 2.30.4.8.10 The CONTRACTOR shall submit a monthly *PCMH Monthly Payment Report* including the data elements described by TENNCARE. These reports shall be submitted no later than the 30th of every month.
- 2.30.4.8.11 The CONTRACTOR shall submit an annual *PCMH Member List for Outcome Panel Report* to participating PCMHs. The Report will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than August 31st of each year.

2.30.4.9 The CONTRACTOR shall submit Tennessee Health Link (THL) Reports as follows:

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- 2.30.4.9.1 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Report* including the data elements described by TENNCARE. Specified data elements shall be reported for each individual provider as described in the template provided by TENNCARE.
- 2.30.4.9.2 The CONTRACTOR shall submit Semi-Annual, a *Tennessee Health Link (THL) Engagement Evaluation Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.
- 2.30.4.9.3 The CONTRACTOR shall submit an annual *Tennessee Health Link (THL) Member list for Outcome Panel Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on September 30<sup>th</sup> of each year.
- 2.30.4.9.4 The CONTRACTOR shall submit a Semi-Annual *Tennessee Health Link (THL) Heat Maps Performance Tracker Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on June 15 and December 15 of each year.
- 2.30.4.9.5 The CONTRACTOR shall submit a Semi-Annual, a *Tennessee Health Link (THL) Quality Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on March 15 and September 15 of each year.
- 2.30.4.9.6 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Provider Sample Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on February 15th, May 15th, August 15, and November 15th of each year.
- 2.30.4.9.7 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Provider Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on February 28th, May 31th, August 31, and November 30th of each year.
- 2.30.4.9.8 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on February 28th, May 31th, August 31, and November 30th of each year.
- 2.30.4.9.9 The CONTRACTOR shall submit a monthly *Tennessee Health Link (THL) Claims Payment Report* including the data elements described by TENNCARE. These reports shall be submitted on the 15th of each month.

**67. Section A.2.30.5 shall be deleted and replaced as follows:**

**A.2.30.5 Population Health Reports**

- 2.30.5.1 The CONTRACTOR shall submit, no later than forty five (45) days after the end of the reporting period, a quarterly *Population Health Update Report* addressing all seven (7) Population Health Programs (see Section A.2.8.4 of this Contract). The report shall include process and operational data and any pertinent narrative to include any staffing changes, training or new initiatives occurring in the reporting period.
- 2.30.5.2 The CONTRACTOR shall submit an annual *Population Health Annual Report* in the format described in the annual report template provided by TENNCARE. The report shall include active participation rates, as designated by NCQA, for programs with active interventions. Short term and intermediate outcome data reporting is required. Member satisfaction shall be reported based upon

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NCQA requirements along with functional status for members in the Chronic Care Management and Complex Case Management programs.

2.30.5.3 The CONTRACTOR shall submit an annual *Population Health Program Description* following the guidance provided by TENNCARE addressing Section A.2.8 of this Contract. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk Level.

**68. Section A.2.30 shall be amended by amending Sections A.2.30.6.5.2, A.2.30.6.6.2, A.2.30.6.6.4, A.2.30.6.6, A.2.30.6.6.11, A.2.30.12.8.2, A.2.30.12.8.5, A.2.30.13.1.2, A.2.30.17.5.2, renumbered Section A.2.30.19.1 and deleting the existing Section A.2.30.19.1, renumbering the remaining Section accordingly including any references thereto, as follows:**

- 2.30.6.5.2 Total number of members enrolled in Group 4, 5, 6, and 7 and in Groups 4, 5, 6, and 7 combined;
- 2.30.6.6 The CONTRACTOR shall submit a quarterly CHOICES and ECF CHOICES Consumer Direction of HCBS Report. MFP participants (see Section A.2.9.8) shall be identified separately for each data element described herein. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:
- 2.30.6.6.1 Total number of members enrolled in Group 2, Group 3, and in Groups 2 and 3 combined;
- 2.30.6.6.2 Total number of members enrolled in Group 4, Group 5, Group 6, and Group 7 and in Groups, 4, 5, 6, and 7 combined;
- 2.30.6.6.3 The number and percent of members in Groups 2 and 3 (combined) enrolled in consumer direction of eligible CHOICES HCBS;
- 2.30.6.6.4 The number and percent of members in Groups 4, 5, 6, and 7 (combined) enrolled in consumer direction of eligible ECF CHOICES;
- 2.30.6.6.11 The total number and the name, SSN, and phone number, and the authorized representative name and phone number, if applicable, of each member referred to the FEA (for enrollment into consumer direction) that has indicated on his Consumer Direction Participation Form that he does not wish to receive HCBS from contract providers pending enrollment into consumer direction, including the member's date of enrollment in CHOICES Group 2 or ECF CHOICES Group 4, 5, 6, or 7, the date of referral to the FEA for consumer direction, and the total number of days that HCBS have not been received by each member.
- 2.30.12.8.2 The number of members in Group 4, Group 5, Group 6, Group 7, and Group 8 and in Groups 4, 5, 6, 7, and 8 combined;
- 2.30.12.8.5 The percent of members in Groups 4, 5, 6, 7, and 8 with a Reportable Event.
- 2.30.13.1.2 The CONTRACTOR shall submit a quarterly 24/7 Nurse Triage Line Report that lists the total calls received by the 24/7 nurse triage line, including the number of calls from CHOICES and ECF CHOICES members, including the ultimate disposition of the call (e.g. education only, no

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referral for care; referred to primary care provider for care, referred to emergency department for care, transfers to a Care Coordinator or Support Coordinator, as applicable (for CHOICES and ECF CHOICES members).

2.30.17.5.2 The number of members in Group 4, Group 5, Group 6, Group 7, and Group 8, and in Groups 4, 5, 6, 7, and 8 combined;

2.30.19.1 The CONTRACTOR shall submit a semi-annual Report on the Activities of the CHOICES Advisory Group regarding the activities of the CHOICES advisory group established pursuant to Section A.2.24.3. This report shall include the membership of the advisory group (name, address, and organization represented), a description of any orientation and/or ongoing training activities for advisory group members, information on advisory group meetings, including the date, time, location, meeting attendees, and minutes from each meeting, and feedback received from community forums. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year

**69. Section A.2.30.10.6 through A.2.30.10.9 shall be deleted from Section A.2.30.10 and moved to Section A.2.30.4 as described herein.**

**70. Section A.2.30.12 shall be amended by adding a new Section A.2.30.12.11 as follows:**

2.30.12.11 The CONTRACTOR shall distribute quarterly *MAT Network Quality Metrics Reports* to all contracted MAT providers on a 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.

**71. Section A.2.30.13 shall be amended by deleting and replacing Section A.2.30.13.3, deleting Sections A.2.30.13.4 and A.2.30.13.5 and renumbering the remaining Section as appropriate, including any references thereto.**

2.30.13.3 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that includes stratification by physical health providers, behavioral health providers, CHOICES (nursing facility and HCBS) providers, and ECF CHOICES HCBS providers. The CONTRACTOR shall submit the report utilizing the template provided annually by TENNCARE. The report shall summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement (see Section A.2.18.7.4) This report shall be submitted by January 30 each year.

**72. Section C.3.11.1.3 shall be amended as follows:**

3.11.1.3 Upon each MFP demonstration participant's completion of community living for the full 365-day demonstration participation period without readmission to a nursing facility (excluding short-term SNF stays solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare) and only until December 31, 2018, a one-time payment of \$5,000.

73. Section E.29.2.2.7 shall be amended by deleting and replacing Level A.17, A.30, A.34, and renumbered Level C.7, adding new Levels A.17(b), B.25 and C.6 as follows and renumbering the remaining Section accordingly, including any references thereto.

LEVEL	PROGRAM ISSUES	DAMAGE
A.17(a)	<p>Failure to comply with the timeframes for developing and approving a PCSP for transitioning CHOICES Group 2 or ECF CHOICES members authorizing and initiating nursing facility services for transitioning CHOICES members in Group 1, or initiating immediately needed and ongoing long-term care services for CHOICES or ECF CHOICES members (see Sections A.2.9.2, A.2.9.3, and A.2.9.6</p>	<p>\$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS) \$10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS) \$15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS) \$20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS)</p> <p>\$25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS) 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>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.</p> <p>This per occurrence amount shall be multiplied by two (2), totaling a \$1,000 per occurrence assessment when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.9 of this Contract</p>
A.17(b)	<p>Failure to complete the intake process in Sections A.2.9.6.2 and A.2.9.6.3 timely, including failure to submit an approved exception request for intake processes lasting more than thirty (30) days due to extenuating circumstances beyond the CONTRACTOR's control</p>	<p>\$500 per day beginning on the next calendar day after the thirtieth (30<sup>th</sup>) calendar day, unless an exception is approved by TENNCARE</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>

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LEVEL	PROGRAM ISSUES	DAMAGE
<b>A.30</b>	<p>Failure to initiate CHOICES HCBS or for children under age 21, EPSDT benefits or ECF CHOICES HCBS, if applicable, provided as an alternative to nursing facility care in accordance with the member's plan of care or PCSP and to ensure that such HCBS or EPSDT benefits are in place immediately upon transition from a nursing facility to the community for any person transitioning from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2, or ECF CHOICES), including persons enrolled in MFP (see Section A.2.9.6.8.16)</p>	<p>\$500 per day for each day that HCBS are not in place following transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) in addition to the cost of services not provided</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>

LEVEL	PROGRAM ISSUES	DAMAGE
<b>A.34</b>	<p>Failure to ensure that a member utilizing the short-term stay benefit is transitioned from Group 2 or Group 3, or ECF CHOICES Group 4, 5, or 6, as applicable, to Group 1 or disenrolled from ECF CHOICES at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members and ECF CHOICES Group 4, 5, or 6 members (see Sections A.2.6.1.5.3.1 and A.2.6.1.5.6)</p>	<p>\$500 per day, per occurrence for each calendar day that a member exceeds the ninety (90) day benefit limit in accordance with this Contract. 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>

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LEVEL	PROGRAM ISSUES	DAMAGE
<b>B.25</b>	Failure to comply with audit requirements as described in this Contract, including but not limited to Section A.2.25.	\$500 per calendar day for each calendar day that TENNCARE determines the CONTRACTOR to be non-compliant with audit requirements and/or requests

LEVEL	PROGRAM ISSUES	DAMAGE
<b>C.6</b>	Failure to submit an inbound 834 within twenty-four (24) hours in accordance with Section A.2.23.5.4 and A.2.23.13.1	\$500 per day, for each calendar day the CONTRACTOR fails to submit an inbound 834 timely and/or accurately (This may be in addition to the damages associated with an applicable corrective action plan in accordance with Section A.2.23.13.1 and Level B.2 herein
<b>C.7</b>	Failure to comply with the requirements regarding documentation for CHOICES or ECF CHOICES members (see Section A.2.9.6)	<p>\$500 per PCSP for members in Group 2 or 3 or in ECF CHOICES that does not include all of the required elements</p> <p>\$500 per member file that does not include all of the required elements</p> <p>\$500 per face-to-face visit where the Care Coordinator or Support Coordinator fails to document the specified observations</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>

74. Attachment VI shall be deleted and replaced as follows:



**Office of Program Integrity  
MCC Referral Documentation Checklist**

Provider/Entity Name: 43T		NPI: 43T	
MCC Investigator/Coder: 43T		Original Referral: <input type="checkbox"/> Amended Referral: <input type="checkbox"/>	
Electronic File Folders – Format (1-15) Required Referral Documents	Included with Referral?		Investigator Comments (If No, explanation required)
	Yes	No	
1) <b>Referral Form and Checklist</b>	<input type="checkbox"/>	<input type="checkbox"/>	43T
2) <b>Audit Report and Findings</b> (Include actual and extrapolated overpayments identified - Excel format)	<input type="checkbox"/>	<input type="checkbox"/>	43T
3) <b>Medical Records Reviewed</b> (PDF format is preferred)	<input type="checkbox"/>	<input type="checkbox"/>	43T
4) <b>Coder-Nurse Reviews</b> (Excel format)	<input type="checkbox"/>	<input type="checkbox"/>	43T
5) <b>Complete Set of Data Reviewed</b> (MCC data universe and SVRS data set - Excel format)	<input type="checkbox"/>	<input type="checkbox"/>	43T
6) <b>Provider Contract</b> (Provider contract with MCC and Provider Participation, history and status)	<input type="checkbox"/>	<input type="checkbox"/>	43T
7) <b>Credentialing Information</b> (Include provider disclosures, if applicable to audit timeframe)	<input type="checkbox"/>	<input type="checkbox"/>	43T
8) <b>Provider Research</b> (Internet research, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	43T
9) <b>Fee Schedules</b> (Include entire audit period - Excel Format)	<input type="checkbox"/>	<input type="checkbox"/>	43T
10) <b>Communication with Provider</b> (Program Integrity related – Prior audits, interviews, etc. Include mail delivery tracking numbers for records request)	<input type="checkbox"/>	<input type="checkbox"/>	43T
11) <b>Pre-Pay Audits</b> (History, reason and status)	<input type="checkbox"/>	<input type="checkbox"/>	43T
12) <b>Policies and Procedures</b> (Authority for denials/NCCI Edit violations, etc. – P&Ps specific to TennCare members only)	<input type="checkbox"/>	<input type="checkbox"/>	43T
13) <b>History of Prior Recoupments</b> (PI related recoupments with date, reason, amounts & supporting data)	<input type="checkbox"/>	<input type="checkbox"/>	43T
14) <b>Provider Education</b> (Targeted education including CAPs is preferred, yet remittance letters and memos are acceptable)	<input type="checkbox"/>	<input type="checkbox"/>	43T

<b>Manager/Team Lead Approval:</b> 43T	<b>Date:</b> 43T
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**Office of Program Integrity  
MCC Potential Provider Fraud and Abuse Referral Form**

(With sample information – delete upon submission)

MCC Information						
Date Submitted	April 3, 2018					
From	Amerigroup/BlueCare/UHCCP/Magellan/DIDD/DentaQuest					
Contact	Investigator Name, e-mail, phone					
Subject						
Provider/Entity Name	Up-coding Family Practice Joe Up-coder, MD (All providers associated with suspected activity)					
Medicaid ID	123456 (Entity) 678910 (Provider)					
NPI	123456789 (Entity) 987654321 (Provider)					
EIN/Tax ID	12-3456789					
Address	1111 Up-coding Dr., Nashville, TN 37205, Phone, Fax					
Provider Type	Physician, NP, Hospital, Transportation					
Specialty	Family Practice, Neurology, etc.					
State Region	Middle TN					
Complaint						
Source/Origination	Tip from employee, Data mining outlier for E&M services, etc.					
Date Reported to MCC	8/1/15					
Description of Suspected Misconduct						
Targeted Procedure Codes Audited/Description	99215-Established patient level 5 office visit (Only want the target procedure codes with a minimum of 30 medical records per code/issue)					
Allegation(s)	Report the alleged misconduct or scheme that was reported to or by the MCC? <u>i.e. Up-coding, Un-bundling, Double Billing, NCCI Edit, Overutilization, Forgery, Kickbacks, Services not Rendered.</u>					
Violation(s)	List the <u>specific</u> statute(s), rules, regulations, CPT guidelines, or MCC policies violated in relation to the allegation.					
Dates of Services Audited	1/1/12-6/30/15 (must be retrospective review)					
Medical Record Type	Electronic and Hard copy					
EHR System	Name, Audit trail available (yes or no)					
MCC Audit Review Findings						
Sample/Exposed Dollar Amount	<b>**Only report the codes here from the sample that substantiated the allegation or codes which had significant findings** All other non-targeted codes can be lumped together. Example:</b>					
		Number of Records/Units with Error	Total Number Records/Units Reviewed	Actual Overpayment Identified	Sample Amount Reviewed	Estimated Extrapolated Overpayment
	99215	25	30	\$15,000	\$20,000	\$50,000
	95165	18	25	\$13,000	\$25,000	\$65,000
	All other Codes	25	125	\$5,500	\$20,000	n/a
<b>Total</b>	<b>68</b>	<b>180</b>	<b>\$33,500</b>	<b>\$65,000</b>	<b>\$115,000</b>	

Amendment 9 (cont.)

<b>Amount Paid to Provider during Audit Period</b>	All claims paid \$1,200,000 99215 \$100,000 95165 \$125,000
<b>Summary of Findings</b>	
<b>Investigative Review</b>	<b><u>Provide a summary of investigation in chronological order.</u></b> (How did MCO receive the tip, what issues were found and actions taken by MCC to substantiate the allegation along with any rules/laws/regulations that the provider presumably violated). Tie the details/facts together as noted above!
<b>Provider History</b>	
<b>Participation</b>	Dates contracted
<b>Disclosure Information</b>	Ownership, Control
<b>Prior Education/CAPs</b>	History, Status (Formal Targeted Education/CAP's/ Not Newsletters or Remittance Letters)
<b>Prepayment</b>	History, Status
<b>Recoupments</b>	History- <b><u>Previous</u></b> recoupments collected by MCC related to Program Integrity concerns of <b><u>fraud, waste or abuse and</u></b> not billing errors, 3 <sup>rd</sup> party liability or claims edit issues.

**TennCare MCC Referral Protocol**

1) The submission of documents related to suspected provider fraud and abuse referrals should be via TennCare SFTP server paths:  
 tncare.sftp.state.tn.us/tncare/MCC###/orr/opi/in  
 tncare.sftp.state.tn.us/tncare/MCC###/orr/tbi/in

2) Concurrently, a notice of submission should be emailed with subject line stating "MCC### Notice of Referral Submission via SFTP" to:  
 ProgramIntegrity.TennCare@tn.gov  
 TBI.MFCU@tn.gov

**3) Addendums will follow steps 1 and 2 above, except submission should be emailed with subject line stating "MCC### Notice of Referral Addendum Submission via SFTP."**

**Required Referral Documents** - Submission of required documents in following folder format is preferred.

- 1) **Referral Form and Checklist**
- 2) **Audit Report and Findings** (Include actual and extrapolated overpayments identified – Excel format)
- 3) **Medical Records Reviewed** (PDF format is preferred)
- 4) **Coder/Nurse Reviews** (Excel format)
- 5) **Complete Set of Data Reviewed** (MCC data universe and SVRS data set – Excel format)
- 6) **Provider Contract** (Provider contract with MCC and Provider Participation, history and status)
- 7) **Credentialing Information** (Include provider disclosures, if applicable to audit timeframe)
- 8) **Provider Research** (Internet research, etc.)
- 9) **Fee Schedules** (Include entire audit period – Excel format)
- 10) **Communication with Provider** (Program Integrity related – Prior audits, interviews, etc. Include mail delivery tracking numbers for records request)
- 11) **Pre-Pay Audits** (History, reason and status, if applicable)
- 12) **Policies and Procedures** (Authority for denials/NCCI Edit violations, etc. – P&Ps specific to TennCare members only)
- 13) **History of Prior Recoupments** (PI related recoupments with date, reason, amounts & supporting data)
- 14) **Provider Education** (Targeted education including CAPs is preferred, yet remittance letters and memos are acceptable)

**Recommended Items to Request**

- Copy of Claim
- Charge Sheet/Super-bill
- Current Recipient Contact Information
- Copy of Recipient's Plan of Care, including medications
- Consent for Treatment
- History and Physical
- Consent Forms
- Assessment Notes
- Physician Orders
- Consult Reports
- Progress Notes (Written and Electronic)
- Procedure Notes
- Prior Authorization forms
- Lab Requisitions/Orders and Results
- Test Requisitions/Orders and Results
- List of Lab Panels, including list of each test per panel
- Drug Screen Requisitions/Test Orders and Results (Qualitative and Quantitative)
- Operative, Radiology, Pathology, ER Reports
- Anesthesia Records
- Immunization and Medication Lot Logs
- All Images from Echo Guides Performed
- Any additional medical records to support services billed

**Supplemental Information to Consider**

- Business Organization Chart
- Ownership Disclosure to Patient
- Patient Care Protocols
- Staff Signature Log
- Licenses/Certifications for All Staff Rendering Care
- Staff, Lab, Billing Agency Contracts
- List of Non-standard Abbreviations Used
- Purchase Orders, Lease Agreements and Maintenance Records for Lab Equipment
- Name and Version of Electronic Health Record (EHR) Software
  - EHR Audit Trail for Records Requested, including list of authorized users and associated IDs



STATE OF TENNESSEE  
Office of Inspector General  
Report TennCare Recipient Fraud



Complete, Print and Mail to:  
State of Tennessee  
Office of Inspector General  
P.O. Box 282368  
Nashville, TN 37228

Or:  
Fax Completed Form to: 615-256-3852  
E-Mail As an Attachment to: [TennCare.Fraud@tn.gov](mailto:TennCare.Fraud@tn.gov)  
TennCare Fraud Hotline: 800-433-3982

Note: In order to be considered for a Cash for Tips reward, you must speak to an OIG representative at 1-800-433-3982. At the time your tip is made, advise the OIG representative that you want a Cash for Tips identification number. **ONLY TIPS SUBMITTED BY TELEPHONE ARE ELIGIBLE FOR A REWARD, AND YOU CANNOT REMAIN ANONYMOUS.**

Please provide as much information as possible. The items marked in **RED** are mandatory fields.

**Name:** \_\_\_\_\_ **Social Security Number (if known):** - - -  
**Other Names Used (maiden, nicknames, etc.):** \_\_\_\_\_  
**Date of Birth (if known):** / / **OR** **Approximate Age:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **AND/OR** **County:** \_\_\_\_\_

**Other Addresses Used:** \_\_\_\_\_

**Please describe the events that lead you to believe TennCare fraud is being committed:**

Have you notified any other local, State or Federal Agencies?  Yes  No  
If yes, who did you notify?

May we contact you if we need additional information?  Yes  No

If so, please provide:

Your Name: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ @ \_\_\_\_\_

Phone Number: - - - - -

Best time to reach you by phone:  Morning  Midday  Afternoon

**75. Attachment VIII shall be deleted and replaced as follows:**

**ATTACHMENT VIII  
DELIVERABLE REQUIREMENTS**

**GENERAL**

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the Division of TennCare unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

**DELIVERABLE ITEMS**

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section A.2.1.1
2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section A.2.5.4
3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section A.2.6.5
4. Request for prior approval of incentives in accordance with Section A.2.6.6
5. Policies and procedures for patient liability that ensure compliance with Section A.2.6.7.2
6. Policies and procedures for self-direction of health care tasks in accordance with Section A.2.7.3
7. Description of health education and outreach programs and activities to ensure compliance with Section A.2.7.4
8. TennCare Kids policies and procedures that ensure compliance with the requirements of Section A.2.7.6
9. Policies and procedures for advance directives that ensure compliance with Section A.2.7.7
10. Population Health program policies and procedures that ensure compliance with Section A.2.8
11. Service coordination policies and procedures that ensure compliance with Section A.2.9.1
12. Implementation plan for making admission, discharge and transfer data from applicable hospitals and pharmacy data available and/or accessible to all primary care practices in accordance with Section A.2.9.1.2.8

Amendment 9 (cont.)

13. Policies and procedures for transition of new members that ensure compliance with the requirements of Section A.2.9.2
14. Policies and procedures for transition of CHOICES members receiving long-term care services at the time of implementation that ensure compliance with Section A.2.9.3
15. Transition of care policies and procedures that ensure compliance with Section A.2.9.5
16. Care coordination and support coordination policies and procedures that ensure compliance with Section A.2.9.6
17. Policies and procedures for consumer direction of eligible CHOICES HCBS and ECF CHOICES HCBS that ensure compliance with Section A.2.9.7
18. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section A.2.9.9
19. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section A.2.9.9.2 to ensure compliance with Section A.2.9.9
20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section A.2.9.10
21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section A.2.9.11
22. Policies and procedures for coordination of dental services that ensure compliance with Section A.2.9.12
23. Identification of members serving on the claims coordination committee in accordance with Section A.2.9.12.5.3
24. Policies and procedures for coordination with Medicare that ensure compliance with Section A.2.9.13
25. Policies and procedures for inter-agency coordination that ensure compliance with Section A.2.9.16
26. Policies and procedures regarding non-covered services that ensure compliance with Section A.2.10
27. Policies and procedures to develop and maintain a provider network that ensure compliance with Section A.2.11.1, including policies and procedures for selection and/or retention of providers
28. Policies and procedures for PCP selection and assignment that ensure compliance with Section A.2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP
29. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section A.2.11.5.2
30. Credentialing manual and policies and procedures that ensure compliance with Section A.2.11.9

Amendment 9 (cont.)

31. Policies and procedures that ensure compliance with notice requirements in Section A.2.11.10
32. Notice of provider and subcontractor termination and additional documentation as required by Section A.2.11.10.2
33. Provider agreement template(s) and revisions to TDCI as required in Section A.2.12
34. Indemnity language in provider agreements if different than standard indemnity language (see Section A.2.12.9.54)
35. Intent to use a physician incentive plan (PIP) to TENNCARE and TDCI (see Section A.2.13.10)
36. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section A.2.13.10)
37. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section A.2.13.11.1
38. Policies and procedures for PCP profiling to ensure compliance with Section A.2.14.9
39. Information on PCP profiling as requested by TENNCARE (see Section A.2.14.9)
40. QM/QI policies and procedures to ensure compliance with Section A.2.15
41. Copy of signed contract with NCQA approved vendor to perform CAHPS as required by Section A.2.15.5
42. Copy of signed contract with NCQA approved vendor to perform HEDIS audit as required by Section A.2.15.5
43. Evidence that NCQA accreditation application submitted and fee paid (Section A.2.15.5.2)
44. HEDIS ROADMAP as required by Section A.2.15.5.2
45. Copy of signed NCQA survey contract as required by Section A.2.15.5.2
46. Notice of date for ISS submission and NCQA on-site review as required by Section A.2.15.5.2
47. Notice of final payment to NCQA as required by Section A.2.15.5.2
48. Notice of submission of ISS to NCQA as required by Section A.2.15.5.2
49. Copy of completed NCQA survey and final report as required by Section A.2.15.5.2
50. Notice of any revision to NCQA accreditation status
51. Policies and procedures regarding critical incident and Reportable Event management and reporting to ensure compliance with Sections A.2.15.7.1 and A.2.15.7.6

Amendment 9 (cont.)

52. Policies and procedures regarding behavioral health adverse occurrence reporting to ensure compliance with Section A.2.15.7.2
53. Report critical incidents or adverse occurrences to TENNCARE within twenty-four (24) hours or four (4) hours, as applicable, pursuant to Sections A.2.15.7.1, A.2.15.7.2, A.2.15.7.3, A.2.15.7.4, A.2.15.7.6.4.1
54. Provider Preventable Conditions Reporting (see Section A.2.15.8)
55. If applicable, information on the use of the name of the CONTRACTOR's TennCare MCO pursuant to Section A.2.16.2
56. Member materials as described in Section A.2.17, including but not limited to, member handbook, quarterly member newsletters, identification card, and provider directory along with any required supporting materials
57. Member services phone line policies and procedures that ensure compliance with Section A.2.18.1
58. Policies and procedures regarding interpreter and translation services that ensure compliance with Section A.2.18.2
59. Provider service and phone line policies and procedures that ensure compliance with Section A.2.18.4
60. Provider handbook that is in compliance with requirements in Section A.2.18.5
61. Provider education and training plan and materials that ensure compliance with Section A.2.18.6
62. Provider relations policies and procedures in compliance with Section A.2.18.7
63. Protocols regarding one-on-one assistance to long-term care providers that ensure compliance with Section A.2.18.7.2
64. Policies and procedures to monitor and ensure provider compliance with the Contract (see Section A.2.18.7.3)
65. Policies and procedures for a provider complaint system that ensure compliance with Section A.2.18.8
66. FEA education and training plan and materials that ensure compliance with Section A.2.18.9
67. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section A.2.18.10
68. Grievance and Appeal policies and procedures that ensure compliance with Section A.2.19
69. Fraud and abuse policies and procedures that ensure compliance with Section A.2.20
70. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section A.2.20.2
71. Fraud and abuse compliance plan (see Section A.2.20.3)

Amendment 9 (cont.)

72. A risk assessment annually and “as needed” (see Section A.2.20.3.2.2)
73. TPL policies and procedures that ensure compliance with Section A.2.21.4
74. Accounting policies and procedures that ensure compliance with Section A.2.21.7
75. Proof of insurance coverage (see Section A.2.21.8)
76. Executed agreement for audit accounts that contains the required language (see Section A.2.21.11)
77. Claims management policies and procedures that ensure compliance with Section A.2.22
78. Internal claims dispute procedure (see Section A.2.22.5)
79. EOB policies and procedures to ensure compliance with Section A.2.22.9
80. Systems policies and procedures, manuals, etc. to ensure compliance with Section A.2.23 (see Section A.2.23.10)
81. Proposed approach for remote access in accordance with Section A.2.23.6.10
82. Information security plan as required by Section A.2.23.6.11
83. Notification of Systems problems in accordance with Section A.2.23.7
84. Systems Help Desk services in accordance with Section A.2.23.8
85. Notification of changes to Systems in accordance with Section A.2.23.9
86. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section A.2.24.2
87. Notification of changes to membership of CHOICES Advisory Group and ECF CHOICES Advisory Group and current membership lists in accordance with Sections A.2.24.3 and A.2.24.4
88. An abuse and neglect plan in accordance with Section A.2.24.6
89. Medical record keeping policies and procedures that ensure compliance with Section A.2.24.8
90. Annual written procedures regarding PERM in accordance with Section A.2.25.6.2.2
91. Subcontracts (see Section A.2.26)
92. HIPAA policies and procedures that ensure compliance with Section A.2.27
93. Notification of breach and provisional breach in accordance with Section A.2.27
94. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section A.2.27

Amendment 9 (cont.)

95. Non-discrimination policies and procedures as required by Section A.2.28
96. Names, resumes, and contact information of key staff as required by Section A.2.29.1.2
97. Changes to key staff as required by Section A.2.29.1.2
98. Staffing plan as required by Section A.2.29.1.8
99. Changes to location of staff from in-state to out-of-state as required by Section A.2.29.1.9
100. Background check policies and procedures that ensure compliance with Section A.2.29.2.1
101. List of officers and members of Board of Directors (see Section A.2.29.3)
102. Changes to officers and members of Board of Directors (see Section A.2.29.3)
103. Eligibility and Enrollment Data (see Section A.2.30.2.1)
104. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section A.2.30.2.2)
105. Quarterly Member Enrollment/Capitation Payment Report (see Section A.2.30.2.3)
106. Information on members (see Section A.2.30.2.4)
107. Annual Community Outreach Plan (see Section A.2.30.3.1)
108. TennCare Kids Quarterly Update (see Section A.2.30.3.2)
109. TennCare Kids Year-End Update (See Section A.2.30.3.3)
110. Psychiatric Hospital/RTF Readmission Report (see Section A.2.30.4.1)
111. Post-Discharge Services Report (see Section A.2.30.4.2)
112. Behavioral Crisis Prevention, Intervention, and Stabilization Services for Individuals with Intellectual or Developmental Disabilities (I/DD) Report (See Section A.2.30.4.3)
113. TennCare Kids Quarterly Outreach Activities Report (see Section A.2.30.4.4)
114. Monthly EPSDT Claims Report (see Section A.2.30.4.5)
115. Provider Engagement Plan (see Section A.2.30.4.6.1)
116. Provider Engagement Tracker Report (see Section A.2.30.4.6.2)
117. Provider Outreach Communication Report (see Section A.2.30.4.6.3)
118. Episodes of Care Performance Reports (see Section A.2.30.4.7.1)

Amendment 9 (cont.)

119. PCMH Membership/Anticipated PCMH Contract Report (see Section A.2.30.4.8.1)
120. PCMH Membership/Contracted PCMH Report (see Section A.2.30.4.8.2)
121. PCMH Risk Band Values for Activity Payments (pmpms) Report (see Section A.2.30.4.8.3)
122. PCMH Practice Type Designations Report (see Section A.2.30.4.8.4)
123. PCMH Heat Maps Performance Tracker Report (see Section A.2.30.4.8.5)
124. PCMH Quality Summary Report (see Section A.2.30.4.8.6)
125. PCMH Provider Sample Reports (see Section A.2.30.4.8.7)
126. PCMH Provider Reports (see Section A.2.30.4.8.8)
127. PCMH Outcome Payment Summary Report (see Section A.2.30.4.8.9)
128. PCMH Monthly Payment Report (see Section A.2.30.4.8.10)
129. PCMH Member List for Outcome Panel Report (see Section A.2.30.4.8.11)
130. Tennessee Health Link (THL) Report (see Section A.2.30.4.9.1)
131. Tennessee Health Link (THL) Engagement Evaluation Summary Report (see Section A.2.30.4.9.2)
132. Tennessee Health Link (THL) Member list for Outcome Panel Report (see Section A.2.30.4.9.3)
133. Tennessee Health Link (THL) Heat Maps Performance Tracker Report (see Section A.2.30.4.9.4)
134. Tennessee Health Link (THL) Quality Summary Report Tennessee Health Link (THL) Quality Summary Report (see Section A.2.30.4.9.5)
135. Tennessee Health Link (THL) Provider Sample Report (see Section A.2.30.4.9.6)
136. Tennessee Health Link (THL) Provider Report (see Section A.2.30.4.9.7)
137. Tennessee Health Link (THL) Summary Report (see Section A.2.30.4.9.8)
138. Tennessee Health Link (THL) Claims Payment Report (see Section A.2.30.4.9.9)
139. Population Health Update Report (see Section A.2.30.5.1)
140. Population Health Annual Report (see Section A.2.30.5.2)
141. Population Health Program Description (see Section A.2.30.5.3)
142. Status of Transitioning CHOICES Members Report (see Section A.2.30.6.1)

Amendment 9 (cont.)

143. CHOICES Nursing Facility Diversion Activities Report (see Section A.2.30.6.2)
144. CHOICES and ECF CHOICES Nursing Facility to Community Transition Report (see Section A.2.30.6.3)
145. Monthly Nursing Facility Short-Term Stay Report (see Section A.2.30.6.4)
146. CHOICES HCBS and ECF CHOICES HCBS Late and Missed Visits Report (see Section A.2.30.6.5)
147. CHOICES and ECF CHOICES Consumer Direction of eligible CHOICES HCBS and ECF CHOICES HCBS Report (see Section A.2.30.6.6)
148. CHOICES Care Coordination Report (see Section A.2.30.6.7)
149. ECF CHOICES Support Coordination Report (see Section A.2.30.6.8)
150. Monthly CHOICES and ECF CHOICES Caseload and Staffing Ratio Report (see Section A.2.30.6.9)
151. Monthly MFP Participants Report (see Section A.2.30.6.10)
152. Members identified as potential pharmacy lock-in candidates (see Section A.2.30.6.11)
153. Pharmacy Services Report (see Section A.2.30.6.12)
154. Pharmacy Services Report, On Request (see Section A.2.30.6.13)
155. Housing Profile Assessment Report (see Section A.2.30.6.14)
156. Community Living Supports and Community Living Supports – Family Model Placement Report (see Section A.2.30.6.15)
157. Community Living Supports and Community Living Supports – Family Model Report (see Section A.2.30.6.16)
158. CHOICES HCBS Point of Service Satisfaction Report (see Section A.2.30.6.17)
159. ECF CHOICES HCBS Point of Service Satisfaction Report (see Section A.2.30.6.18)
160. ECF CHOICES Employment Report (see Section A.2.30.6.19)
161. ECF CHOICES Reimbursement Services Report (see Section A.2.30.6.20)
162. Meeting the Urgent (RED FLAG) Needs of Members during Transition Report (see Section A.2.30.6.21)
163. Semi-Annual HH/PDN Coordination Report (see Section A.2.30.6.22)
164. Monthly HH/PDN Coordination Report (see Section A.2.30.6.23)
165. Weekly Member MCO Selection/Assignment Report (see Section A.2.30.6.24)

Amendment 9 (cont.)

166. Provider Enrollment File (see Section A.2.30.8.1)
167. Provider Compliance with Access Requirements Report (see Section A.2.30.8.2)
168. PCP Assignment Report (see Section A.2.30.8.3)
169. Report of Essential Hospital Services (see Section A.2.30.8.4)
170. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness (see Section A.2.30.8.5)
171. Quarterly Behavioral Health Appointment Timeliness Summary Report (see Section A.2.30.8.6)
172. CHOICES and ECF CHOICES Qualified Workforce Strategies Report (see Section A.2.30.8.7)
173. FQHC Reports (see Section A.2.30.8.8)
174. Quarterly CHOICES and ECF CHOICES Provider Background Check Report (see Section A.2.30.8.9)
175. Quarterly HCBS Settings Report (see Section A.2.30.8.10)
176. Behavioral Health Service Matrix Report (see Section A.2.30.8.11)
177. Related Provider Payment Report (see Section A.2.30.10.1)
178. Check Run Summaries Report (see Section A.2.30.10.2)
179. Claims Data Extract Report (see Section A.2.30.10.3)
180. Reconciliation Payment Report (see Section A.2.30.10.4)
181. Administrative Services Only Invoice Report (See Section A.2.30.10.5)
182. Cost and Utilization Reports (see Section A.2.30.11.1)
183. Cost and Utilization Summaries (see Section A.2.30.11.2)
184. Identification of high-cost claimants (see Section A.2.30.11.3)
185. CHOICES and ECF CHOICES Utilization Report (see Section A.2.30.11.4)
186. Referral Provider Listing and supporting materials (see Section A.2.30.11.5)
187. Behavioral Health Coverage Annual Report (see Section A.2.30.11.6)
188. Report on Performance Improvement Projects (see Section A.2.30.12.1)
189. NCQA Accreditation Report (see Section A.2.30.12.2)
190. NCQA revaluation of accreditation status based on HEDIS scores (see Section A.2.30.12.3)

Amendment 9 (cont.)

191. Medicaid HEDIS measures marked as “Not Reported” (see Section A.2.30.12.4)
192. Reports of Audited HEDIS Results (see Section A.2.30.12.5)
193. Reports of Audited CAHPS Results (see Section A.2.30.12.6)
194. CHOICES HCBS Critical Incidents Report (see Section A.2.30.12.7)
195. ECF CHOICES HCBS Reportable Event Report (see Section A.2.30.12.8)
196. Behavioral Health Adverse Occurrences Report (see Section A.2.30.12.9)
197. Settings Compliance Committee Report (see Section A.2.30.12.10)
198. MAT Network Quality Metrics Reports (see Section A.2.30.12.11)
199. Member Services, Provider Services, and Utilization Management Phone Line Report (see Section A.2.30.13.1.1)
200. 24/7 Nurse Triage Line Report (see Section A.2.30.13.1.2)
201. Provider Satisfaction Survey Report (see Section A.2.30.13.3)
202. Member Complaints Report (see Section A.2.30.14)
203. Fraud and Abuse Activities Report (see Section A.2.30.15.1)
204. Policies in compliance with Section 1902(a)(68) of the Social Security Act (see Section A.2.30.15.3)
205. Disclosure Submission Rate Report (see Section A.2.30.15.4)
206. Program Integrity Exception List Report (see Section A.2.30.15.5)
207. List of Involuntary Terminations Report (see Section A.2.30.15.6)
208. Recovery and Cost Avoidance Report (see Section A.2.30.16.1.1)
209. Medical Loss Ratio (MLR) Report (see Section A.2.30.16.2.1)
210. Ownership and Financial Disclosure Report (see Section A.2.30.16.2.2)
211. Annual audit plan (see Section A.2.30.16.2.3)
212. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section A.2.30.16.3.1)
213. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section A.2.30.16.3.2)

Amendment 9 (cont.)

214. Annual Financial Report (to TDCI) (see Section A.2.30.16.4.3)
215. Quarterly Financial Report (to TDCI) (see Section A.2.30.16.3.4)
216. Audited Financial Statements (to TDCI) (see Section A.2.30.16.3.5)
217. Claims Payment Accuracy Report (see Section A.2.30.17.1)
218. Monthly Focused Claims Testing Report (see Section A.2.30.17.2)
219. EOB Report (see Section A.2.30.17.3)
220. Claims Activity Report (see Section A.2.30.17.4)
221. CHOICES and ECF CHOICES Cost Effective Alternatives Report (see Section A.2.30.17.5)
222. Quarterly Denied Claims Report (See Section A.2.30.17.6)
223. Systems Refresh Plan (see Section A.2.30.18.1)
224. Encounter Data Files (see Section A.2.30.18.2)
225. Electronic version of claims paid reconciliation (see Section A.2.30.18.3)
226. Encounter/MLR Reconciliation Report (see Section A.2.30.18.4)
227. Information and/or data to support encounter data submission (see Section A.2.30.18.5)
228. Systems Availability and Performance Report (see Section A.2.30.18.6)
229. Business Continuity and Disaster Recovery Plan (see Section A.2.30.18.7)
230. Report on the Activities of the CONTRACTOR's CHOICES Advisory Group (see Section A.2.30.19.1)
231. Report on the Activities of the CONTRACTOR's ECF CHOICES Advisory Group and member-only advisory group (see Section A.2.30.19.2)
232. Subcontracted claims processing report (see Section A.2.30.20.1)
233. HIPAA/HITECH Report (*Privacy/Security Incident Report*) (see Section A.2.30.21)
234. Non-discrimination policy (see Section A.2.30.22.1)
235. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section A.2.30.22.2)
236. Non-Discrimination Compliance Report (see Section A.2.30.22.3)
237. Disclosure of conflict of interest (see Section A.2.30.23.1)

Amendment 9 (cont.)

- 238. Attestation Re: Personnel Used in Contract Performance (see Section A.2.30.23.2)
  - 239. ECF CHOICES Initiation of Services Report (see Section A.2.30.24)
  - 240. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section C.3.7.1.2.1
  - 241. Return of funds in accordance with Section C.5
  - 242. Termination plan in accordance with Section E.14.8
  - 243. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI
  - 244. NEMT Reports (see Section A.19 of Attachment XI)
- 76. Attachment XI shall be amended by deleting and replacing Sections A.3.2, A.4.1.2.5, A.4.3.1.1, A.8.3.11, No. 2 of Exhibit F, adding new Sections A.4.3.4, A.17.5.5, A.19.1.6, A.19.1.7, A.19.4.3 as follows, and renumbering the remaining Sections as appropriate, including any references thereto.**
- A.3.2** Requests for NEMT services should be made at least seventy-two (72) hours based on calendar days before the NEMT service is needed. However, this timeframe does not apply to urgent trips (see Section A.5.7 of this Attachment), scheduling changes initiated by the provider, and follow-up appointments when the timeframe does not allow advance scheduling. In addition, the CONTRACTOR shall accommodate requests for NEMT services that are made within the following timeframes: three (3) hours before the NEMT service is needed when the pick-up address is in an urban area and four (4) hours before the NEMT service is needed when the pick-up address is in a non-urban area. The CONTRACTOR shall provide additional education to members who fail to request transportation seventy-two (72) hours before the NEMT service is needed (see Section A.10 of this Attachment).
- A.4.1.2.5 Approve or deny the request. Transportation shall not be denied for a member with minor children with whom daycare could not be arranged when a member established the need for them to be included in order to reserve space and child restraint upon scheduling of the trip; and
- A.4.3.1.1 If the criteria in Section A.4.2 of this Attachment are met, the CONTRACTOR shall determine what mode of transportation is appropriate to meet the needs of the member. The modes of transportation that shall be covered by the CONTRACTOR include, but are not limited to: fixed route, multi-passenger van, wheelchair van, invalid vehicle, ambulance and member mileage reimbursement program.

Amendment 9 (cont.)

A.4.3.4 Member Mileage Reimbursement

The CONTRACTOR shall follow policies and procedures as provided by TENNCARE when utilizing this method of transportation. Reporting requirements are specified in Section A.19 of this Attachment.

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry and the equivalent registry showing data from all fifty (50) states prior to providing services under this Contract and every year thereafter. This is in addition to the criminal background check and results shall be maintained in the driver's file as to allow for unscheduled file audits.

A.17.5.5 The CONTRACTOR shall assure that surveys are conducted for randomly selected members within twenty-four (24) hours (when conducted by phone) of receiving the service or within a week (when conducted via postal service) throughout the calendar year at a minimum not to exceed a quarterly basis. One percent (1%) of trips provided should be surveyed and responded to during each calendar quarter. Results are reported annually using a quarterly breakdown.

A.19.1.6 Member Mileage Reimbursement Report. The CONTRACTOR shall submit a quarterly MMR report utilizing the template provided by TENNCARE.

A.19.1.7 Provider Send Back Report. The CONTRACTOR shall provide a monthly Provider Send Back report which includes the name of NEMT provider, name of TennCare Member, date the trip was scheduled with call center, the appointment date and the date the provider sent the unaccepted trip back utilizing the template provided by TENNCARE.

A.19.4.3 The CONTRACTOR shall submit a monthly NEMT claims status report. The report shall include the number of claims received, total paid claims, total denied claims and the total of pended claims by the NEMT brokerage for the previous months activity.

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
2	Comply with the approval and scheduling requirements (see Section A.5.1 of this Attachment)	Up to \$1,000 per deficiency at TENNCARE's discretion

Amendment 9 (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, 2019.

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:** \_\_\_\_\_  
*Larry B. Martin*  
*Commissioner*

**BY:** \_\_\_\_\_  
*Edna Willingham*  
*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, 2019			
Current Request Amendment Number: <i>(if applicable)</i>	9					
Proposed Amendment Effective Date: <i>(if applicable)</i>	January 1, 2019					
*Department Submitting:	Department of Finance and Administration					
*Division:	Division of TennCare					
*Date Submitted:	October 31, 2018					
*Submitted Within Sixty (60) days:	Yes					
<i>If not, explain:</i>	N/A					
*Contract Vendor Name:	AMERIGROUP Tennessee, Inc.					
*Current or Proposed Maximum Liability:	\$ 9,815,423,650.00					
*Estimated Total Spend for Commodities:	N/A					
<b>*Current or Proposed Contract Allocation by Fiscal Year: (as Shown on Most Current Fully Executed Contract Summary Sheet)</b>						
<b>FY: 2014</b>	<b>FY: 2015</b>	<b>FY: 2016</b>	<b>FY: 2017</b>	<b>FY: 2018</b>	<b>FY: 2019</b>	<b>FY: 2020</b>
0.00	\$927,757,750	\$1,887,665,900	\$2,000,000,000	\$2,000,000,000	\$2,000,000,000	\$1,000,000,000
<b>*Current Total Expenditures by Fiscal Year of Contract: (attach backup documentation from Edison)</b>						
<b>FY: 2014</b>	<b>FY: 2015</b>	<b>FY: 2016</b>	<b>FY: 2017</b>	<b>FY: 2018</b>	<b>FY: 2019</b>	<b>FY: 2020</b>
0.00	\$654,157,439.34	\$1,719,763,765.88	\$1,759,964,650.17	\$1,415,428,963.75		
<b>IF</b> Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:				N/A		
<b>IF</b> surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:				N/A		
<b>IF</b> Contract Expenditures exceeded Contract Allocation, please give the				N/A		

Supplemental Documentation Required for  
Fiscal Review Committee

reasons and explain how funding was acquired to pay the overage:			
*Contract Funding Source/Amount:			
State:	\$3,398,179,820.00	Federal:	\$6,417,243,830.00
<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		
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	TennCare googled this contractor and did not identify any illegal activity.		

Supplemental Documentation Required for  
Fiscal Review Committee

<p>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.</p>	<p>Language in the contract requires immediate notification to the state regarding illegal activity or fraud if discovered during the Contract term.</p>
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## CONTRACT AMENDMENT COVER SHEET

<b>Agency Tracking #</b> 31865-00372	<b>Edison ID</b> 40180	<b>Contract #</b>	<b>Amendment #</b> 08		
<b>Contractor Legal Entity Name</b> AMERIGROUP Tennessee, Inc.			<b>Edison Vendor ID</b> 0000011035		
<b>Amendment Purpose &amp; Effect(s)</b> Extends Term One Year, Increases Maximum Liability					
<b>Amendment Changes Contract End Date:</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<b>End Date:</b> December 31, 2019			
<b>TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):</b>			<b>\$ 2,000,000,000.00</b>		
<b>Funding —</b>					
<b>FY</b>	<b>State</b>	<b>Federal</b>	<b>Interdepartmental</b>	<b>Other</b>	<b>TOTAL Contract Amount</b>
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	\$341,420,000.00	\$658,580,000.00			\$1,000,000,000.00
<b>TOTAL:</b>	<b>\$3,398,179,820.00</b>	<b>\$6,417,243,830.00</b>			<b>\$9,815,423,650.00</b>
<b>American Recovery and Reinvestment Act (ARRA) Funding:</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
<b>Budget Officer Confirmation:</b> 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>		
<b>Speed Chart (optional)</b>		<b>Account Code (optional)</b>			

AMERIGROUP Tennessee, Inc.  
Edison Contract ID: 40180

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	<u>\$151,889,501.16</u>	(Expenditures through July 25, 2018, 2018)
TOTAL	<u><u>\$6,201,053,541.21</u></u>	

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
			<b>\$255,884,204.31</b>	

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
			<b>\$398,273,235.03</b>	

**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
			<b>\$421,567,147.15</b>	

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
			<b>\$540,412,643.95</b>	

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
			<b>\$297,991,178.86</b>	

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
			<b>\$459,792,795.92</b>	

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**FY 2016 TOTAL**

**\$1,719,763,765.88**

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# 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
			<b>\$468,871,772.59</b>	

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
			<b>\$489,706,313.65</b>	

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
			<b>\$388,421,586.61</b>	

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
			<b>\$412,964,977.32</b>	

**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
			<b>\$401,967,693.14</b>	

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
			<b>\$476,875,764.29</b>	

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
			<b>\$536,585,506.32</b>	
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

**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
			<b>\$499,849,220.91</b>	

**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
			<b>\$151,889,501.16</b>	

**FY 2019 TOTAL**

**\$151,889,501.16**