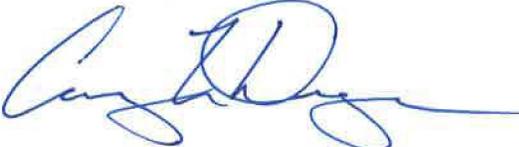




## INTERAGENCY AGREEMENT SUMMARY

(Interagency Agreement between state agencies, including the University of Tennessee or Board of Regents colleges and universities)

<b>Begin Date</b> July 1, 2015	<b>End Date</b> June 30, 2018	<b>Agency Tracking #</b> 31865-00005	<b>Edison ID</b> 46266		
<b>Contracting State Agency Name</b> Department of Intellectual and Developmental Disabilities					
<b>CFDA #</b> 93.778 Dept of Health & Human Services/Title XIX					
<b>Service Caption</b> Home and Community Based Services (HCBS) Waiver Program Services					
<b>Funding —</b>					
<b>FY</b>	<b>State</b>	<b>Federal</b>	<b>Interdepartmental</b>	<b>Other</b>	<b>TOTAL Agreement Amount</b>
2016	\$24,710,000.00	\$24,710,000.00			\$49,420,000.00
2017	\$24,710,000.00	\$24,710,000.00			\$49,420,000.00
2018	\$24,710,000.00	\$24,710,000.00			\$49,420,000.00
<b>TOTAL:</b>	<b>\$74,130,000.00</b>	<b>\$74,130,000.00</b>			<b>\$148,260,000.00</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 - IA</i>		
<b>Speed Chart (optional)</b>		<b>Account Code (optional)</b>			



**INTERAGENCY AGREEMENT BETWEEN THE STATE OF TENNESSEE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION  
BUREAU OF TENNCARE  
AND  
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES**

This Interagency Agreement (Interagency Agreement), by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), Bureau of TennCare, hereinafter referred to as the "Procuring State Agency" or "TennCare" and the Department of Intellectual and Developmental Disabilities, hereinafter referred to as the "Contractor," or "DIDD," or "Contracting State Agency" is for the provision of services through three (3) Centers for Medicare and Medicaid Services (CMS) 1915(c) Home and Community Based Services (HCBS) Waiver programs to eligible Medicaid recipients with intellectual disabilities, as further defined in the "SCOPE OF SERVICES."

WHEREAS, pursuant to T.C.A. § 71-5-104(a), the Tennessee Department of Health has designated TennCare as the single State Medicaid agency to administer the State medical assistance services, known as the TennCare Program, as provided for in Title XIX of the Social Security Act as amended ( 42 U.S.C. § 1396 et seq.), or as provided by any federal waiver received by the State that waives any or all of the provisions of Title XIX or pursuant to any other federal law as adopted by amendment to the required Title XIX State plan; and,

WHEREAS, All Parties agree that this Interagency Agreement does not constitute any delegation by TennCare of Medicaid policy and decision making authority; and

WHEREAS, TennCare and DIDD have obtained approval from CMS for three (3) 1915(c) Home and Community Based Services Waivers known as the Statewide Waiver (waiver control #0128), the Comprehensive Aggregate Cap Waiver (waiver control #0357), and the Self-Determination Waiver (waiver control #0427), collectively referred to herein as the "Waiver";

NOW, THEREFORE, in consideration of mutual promises herein contained, the parties have agreed and do hereby enter into this Interagency Agreement according to the provisions set out herein.

**A. SCOPE OF SERVICES:**

- A.1. The Contracting State Agency shall provide all goods, services or deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Interagency Agreement.
- A.2. The Contractor shall provide Waiver services specified in the approved Waiver in accordance with the needs of the individual service recipient as set forth in the approved plan of care (i.e., Individual Service Plan (ISP)), and ensure, pursuant to 42 C.F.R § 441.302, *State Assurances*, that such services are accessible in a timely manner, provided in accordance with state and federal laws and regulations, TennCare policies and procedures, and the approved Waiver, and administered in the most cost-effective way possible in order to maximize the number of persons with access to Waiver services. DIDD shall implement a system of reviewing and approving plans of care at least annually and as frequently as needed to ensure that the type and amount of Waiver services provided are those without which the individual would require the services of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
- A.3. The Contractor shall draft Waiver policies and procedures for review and written approval by TennCare prior to their public posting and implementation. For purposes of this Interagency Agreement, policies and procedures shall include the Provider Manual, all written policies and protocols and training materials pertaining thereto, any additional provider requirements or interpretive guidelines applicable to the Waiver programs, memoranda pertaining to the Waiver



programs, and all notices, correspondence and other written materials that will be provided to service recipients, providers, advocates or the public regarding the Waiver programs, including but not limited to, information regarding eligibility, enrollment, services, and appeal rights

DIDD shall provide to TennCare on a monthly basis a report listing all approved and pending policies and procedures and the date of submission to TennCare. The report shall be delivered in a format developed by DIDD and approved by TennCare.

DIDD shall advise TennCare in advance of submission of any Administration bills that would affect the Waiver programs, submit to TennCare for review and comment prior to their release to third parties any proposed budgetary requests, presentations to the Tennessee General Assembly, and legislative or public reports regarding the Waiver programs; and shall advise TennCare in advance of any public discussion of any proposed changes to the Waiver programs, including proposed Waiver amendments, proposed modifications to the TennCare or DIDD Rules pertaining to the Waiver programs, or proposed changes in Waiver service payment rates or methodologies.

- A.4. The Contractor shall submit for review and approval any solicitations for services provided or required in the Waiver programs, and all contracts funded in whole or in part with federal dollars prior to the execution of such contracts.
- A.5. The Contractor shall designate specific staff to serve as liaison to TennCare regarding the following: Waiver policy, operations, appeals, quality management, claims, federal investigations and inquiries, the Money Follows the Person Rebalancing Demonstration Grant (MFP), Program Integrity, privacy officials, Interagency Agreement compliance, and other subject matters as requested by TennCare. DIDD shall submit to TennCare a list in writing of each contact person's name, title and contact information. The list shall be reviewed and resubmitted by the Contractor to TennCare by January 15 annually. Any time there is a change to staffing in any of the positions listed above, the list must be updated and resubmitted to TennCare within one (1) week of the change.
- A.6. The Contractor shall identify and designate staff in all regional offices who will be responsible for the data entry of each Waiver participant into TennCare's electronic Tennessee Pre-Admission Evaluation System (TPAES).
- A.7. The Contractor shall utilize TPAES to facilitate enrollment of eligible individuals into and transitions between Long-Term Services and Support (LTSS) programs, including ICF/IID, DIDD HCBS Waivers and the State's MFP Rebalancing Demonstration (MFP), and shall comply with all data collection processes and timelines established by TennCare in policy or protocol in order to gather data required to comply with tracking and reporting requirements. For MFP participants this shall include, but is not limited to, current residence type and address, date of enrollment request, date of projected transition date if applicable, date of actual transition within two (2) business days of the transition taking place, attestations pertaining to Eligible Individual and Qualified Residence (MFP), changes in residence, inpatient facility stays, reasons for re-institutionalization, and reasons for disenrollment.
- A.8. The Contractor shall maintain and shall make available to TennCare, upon request, an up-to-date list of unduplicated participants served in each Waiver during the program year, and an up-to-date list of active participants in each Waiver program.

The Contractor shall be responsible for developing and maintaining a process for enrollment of new Waiver enrollees, including criteria for enrollment and deferment.

- A.9. The Contractor shall ensure, prior to Waiver enrollment, that individuals are given the freedom of choice to choose between institutional care in an ICF/IID and the Waiver and that a TennCare-approved Freedom of Choice Form is appropriately completed by the enrollee.



- A.10. The Contractor shall ensure that there is an initial certification by a physician of the Waiver enrollee's need for care in the Waiver, in accordance with TennCare policies and procedures.
- A.11. The Contractor shall ensure that each Waiver enrollee receives physician services as needed and in accordance with TennCare periodicity and other guidelines.
- A.12. The Contractor shall ensure that each Waiver enrollee has an individualized written ISP, as defined by TennCare and pursuant to Person-Centered Planning Rule specified in 42 C.F.R. § 441.301(c), which is developed within sixty (60) calendar days of admission into the Waiver and shall monitor the ISP in accordance with TennCare policies and procedures. The ISP shall be updated on an as needed basis in the event of significant changes in the enrollee's needs.

The Contractor shall further ensure that each provider signs the ISP indicating they understand and agree to provide the services as described prior to the scheduled implementation of services and prior to any change in such services. The Contractor shall have mechanisms in place to ensure that such signatures and confirmation of each provider's agreement to provide services occur in a timely manner, such that a delay in the initiation of services does not result. Electronic signatures will be accepted for providers who are not present during the care planning process or as needed to facilitate timely implementation, including updates to the ISP based on the service recipient's needs.

- A.13. The Contractor shall perform an annual reevaluation of the Waiver enrollee's need for continued stay in the Waiver, in accordance with TennCare policies and procedures and to ensure that all service recipients continue to meet ICF/IID level of care criteria. The Contractor may also be required to perform additional re-evaluations of the enrollee's need for continued stay in the Waiver based on changes in the enrollee's medical condition.
- A.14. The Contractor shall maintain comprehensive individual records and documentation of services to Waiver enrollees, in accordance with state and federal laws and regulations, TennCare rules, policies and procedures, court orders.
- A.15. Waiver Disenrollments. The Contractor shall develop and implement policies and procedures for DIDD staff which comport with the requirements of this section. The Contractor shall be responsible for maintaining documentation indicating the criteria and associated timelines for processing involuntary and voluntary disenrollments, to be made available to TennCare upon request.
  - a. Involuntary Disenrollments. Involuntary disenrollments are subject to approval by TennCare. The Contractor shall provide TennCare with written notification of any enrollee's involuntary Waiver disenrollment prior to the actual disenrollment as specified by TennCare. Prior to submission to TennCare, the Contractor shall ensure all documentation is complete and accurate.
  - b. Voluntary Disenrollments. Upon becoming aware of any voluntary disenrollment (e.g. receiving a request for a voluntary disenrollment or identifying the need for a voluntary disenrollment), DIDD shall process the disenrollment and notify TennCare within no more than five (5) business days of becoming aware of such disenrollment, in a format developed by DIDD and approved by TennCare.
  - c. The Contractor shall be responsible for maintaining a comprehensive listing of all voluntary and involuntary disenrollments from any DIDD Waiver, submitted to TennCare in a format and frequency developed by DIDD and approved by TennCare. The listing should include, but is not limited to, the following information: full name and Social Security number of person disenrolled; DIDD Region; DIDD Waiver; date enrolled/disenrolled from DIDD Waiver; whether disenrollment was voluntary or involuntary; reason for disenrollment; date the notification letter was sent to the individual; and date of notification to TennCare regarding the disenrollment.



- A.16. The Contractor shall ensure that enrollees are informed that they are receiving Waiver s and are subject to visits by the State in their homes or residences at any time to meet the assurances of health, safety and welfare monitoring required by the Centers for Medicare Medicaid Services (CMS).
- A.17. The Contractor shall provide TennCare with quarterly notification of service recipients who are in an institutional stay. For the purpose of this Interagency Agreement, an institutional stay shall mean any instance in which a service-recipient has a planned or unplanned admission in a hospital, psychiatric hospital, nursing facility, or intermediate care facility for ICF/IID. The Contractor shall further provide progress reports/updates as requested by TennCare.
- A.18. The Contractor shall ensure that, on the sixtieth (60th) consecutive day of such institutional stay, the individual is provided thirty (30) days advance notice of disenrollment from the Waiver program including applicable appeal rights. Unless the individual is discharged from institutional care within the thirty (30) day advance notice period or a timely filed appeal regarding such disenrollment is received, disenrollment from the Waiver proceeds immediately on the ninetieth (90<sup>th</sup>) consecutive day of institutional stay or upon resolution of a timely filed appeal regarding such disenrollment, if applicable; or, if such institutional stay does not exceed ninety (90) consecutive days, that appropriate plans are developed to facilitate transition within the ninety (90) day timeframe.
- The Contractor shall ensure that all Waiver enrollees participating in an institutional stay are assessed to determine the circumstances resulting in the institutional stay and whether the individual has experienced a deterioration in health or functional status. For individuals who have experienced a deterioration in health or functional status, the Contractor shall evaluate whether the services and supports outlined in the Individual Support Plan (ISP) are sufficient to safely meet his/her needs in the community such that continued participation in the DIDD HCBS Medicaid Waiver is appropriate and amend the ISP, as necessary, to adequately address the individual's needs upon discharge. For both admission and discharge planning, it is expected that the Contractor notifies and coordinates with the individual's MCO.
- A.19. The Contractor shall implement and comply with a TennCare-approved grievance and appeals process and, as required by TennCare, provide expert testimony by appropriate professionals during contested case hearings.
- A.20. The Contractor shall comply with all notice and appeal requirements, processes and timelines specified in federal regulation as modified or enhanced pursuant to the *Grier* Revised Consent Decree or other applicable federal court orders, and with all TennCare Rules, policies and procedures pertaining to such requirements, processes and timelines. The Contractor shall forward an expedited appeal to TennCare in twenty-four (24) hours or a standard appeal in five (5) days.
- A.21. The Contractor shall cooperate fully with TennCare in all matters of litigation affecting the Waiver programs, and in all federal, state or TennCare investigations and/or inquiries. DIDD shall be required to timely furnish all evidence, assistance, and to provide general and expert testimony as requested by TennCare in connection with these matters. DIDD shall immediately notify and forward to TennCare information pertaining to litigation, federal or state investigations and/or inquiries affecting Waiver programs and shall not enter into any Settlement Agreements which have the potential to impact existing Medicaid programs (including the Medicaid State Plan, TennCare 1115 Demonstration Waiver, or Section 1915(c) Waivers ), or that could require the development of new Waiver programs without the knowledge and approval of TennCare.
- A.22. The Contractor shall verify, prior to enrollment and on an ongoing basis, that vendors/providers meet applicable provider qualification standards, including certification, licensure, and other requirements, as applicable, in accordance with state and federal regulations, applicable court orders, TennCare rules, policies and procedures, and Waiver requirements. The requirements for the screening of Billing Providers and the enrolling of Ordering and Referring Providers shall be



met as contained in A.41. DIDD shall review all Waiver provider applications and shall cc that the applicant meets such standards and qualifications prior to submission of the app to TennCare. Any qualified provider who undertakes to provide HCBS and meets specific reimbursement, quality, and utilization standards shall not be restricted from participating in these Waiver programs.

A.23. The Contractor shall ensure, as part of the provider application process, that all information provided by the provider in its application is validated, current and accurate in order to receive payment directly from TennCare. The Contractor shall also ensure that provider applications are reviewed timely and that applicants are issued written notice of approval or rejection of the application within sixty (60) days of receipt of the application and all required attachments.

A.24. The Contractor shall ensure that all licensed HCBS settings in which a Waiver enrollee resides or receives services meets all applicable fire and safety codes.

The Contractor shall ensure, prior to contracting with a new provider and as part of on-going monitoring of existing providers, that all HCBS settings where Medicaid-reimbursed services are provided are compliant with the CMS HCBS Settings Rule 42 C.F.R. § 441.301(c)(4)-(5) and in accordance with the state's approved transition plan.

A.25. The Contractor shall perform quality assurance/improvement assessments of Waiver services and providers and report such findings to TennCare, in accordance with TennCare policies and procedures.

A.26. The Contractor shall generate claims for authorized services provided to each Waiver participant. The Contractor shall submit provider claims to TennCare at a minimum of twice per month.

Reimbursement shall be made by TennCare directly to providers based on claims processed through the Medicaid Management Information System (MMIS). TennCare direct payment for Waiver services will be the lesser of the billed charge or maximum reimbursement rate established in the TennCare Maximum Reimbursement Rate Schedule.

The Contractor shall ensure that provider claims are reconciled against approved ISPs prior to submission of such claims to TennCare, and that claims in excess of service benefit limits as defined in the maximum rate sheet established by TennCare are not submitted to TennCare.

The Contractor shall ensure that annual Waiver expenditures do not exceed the annual appropriation by the General Assembly for Waiver program expenditures.

The Contractor shall ensure that for each individual enrolled in the Statewide Waiver that individual expenditures do not exceed the established individual cost neutrality cap.

The Contractor shall establish policies and processes to ensure each Statewide Waiver enrollee's ISP does not authorize services in excess of the individual cost neutrality cap and shall track and monitor all ISP Waiver service authorization submissions for appropriateness and accuracy.

A.27. The Contractor shall collect patient liability as determined by TennCare and in accordance with TennCare policy, ensure that no Medicaid funds are expended for room and board in home and community based residential settings, and safeguard the personal funds of service recipients. DIDD shall provide for an independent audit of each Waiver program (except as CMS may otherwise specify for particular Waivers), and shall maintain and make available to the U.S. Department of Health and Human Services (HHS), the Comptroller, TennCare, or other designees, appropriate financial records documenting the cost of services provided under the Waiver, including reports of any independent audits conducted.



- A.28. The Contractor shall provide TennCare with a copy of all termination notices that the Contractor sends to Waiver providers, and shall send such notices to TennCare in a manner specified in TennCare prior to termination of the provider contract. When termination of a provider contract results from an issue of enrollee safety, which shall include any instance in which DIDD and TennCare have determined, based on quality concerns, that a provider should not be allowed to continue to provide services to Waiver participants, the Contractor shall notify TennCare immediately.
- A.29. The Contractor shall perform expenditure and revenue reporting in accordance with state and federal requirements.
- A.30. The Contractor shall comply with state and federal rules, laws and regulations, all applicable federal and state court orders including, but not limited to, those set forth in *Grier v. Goetz*, CMS HCBS Settings and Person-Centered Planning Rules in 42 C.F.R. § 441.301(c), and TennCare policies and procedures in the administration of the Waiver.
- A.31. The Contractor shall provide TennCare with at least ten (10) business days advance notice of any scheduled public meetings or provider trainings to be conducted with a group of providers or coordinated by DIDD pertaining to the Waiver programs, including the date, time, and location for each meeting or training. If a meeting is rescheduled, the Contractor shall notify TennCare as soon as possible. Agendas for the meetings related to TennCare and/or Medicaid-funded services or Waivers shall be sent to TennCare prior to the meeting. All other agendas are to be made available upon request.
- A.32. The Contractor shall operate the Waiver programs in a manner that comports with all federal waiver assurances and sub-assurances as specified in 42 C.F.R. § 441.302 and as approved in the Statewide Waiver (waiver control #0128) and in the Comprehensive Aggregate Cap (CAC) Waiver (waiver control #0357), including, but not limited to, compliance with administrative authority, level of care, service plan, health and welfare, qualified providers, and financial accountability.

DIDD shall implement a Quality Assurance system in accordance with the Quality Improvement (QI) Strategy set forth in the approved Waiver application for each Waiver program which includes discovery, remediation and improvement activities and which produces evidence that such assurances and sub-assurances are in fact being met. DIDD shall be responsible for ensuring that all individual findings are remediated within no more than thirty (30) days of discovery, and that documentation of such timely remediation is both accurate and complete. DIDD shall be responsible for identifying providers with systemic performance issues and providing technical assistance/provider support and/or sanctions as necessary to address the issues and ensure quality improvement. DIDD shall also be responsible for taking appropriate actions to address statewide systemic issues (performance measures for which the compliance percentage is at or below eighty five percent (85%) for more than three (3) months of the year and/or has been persistently below that threshold (i.e. for three (3) months or more) during previous years, for monitoring the efficacy of such actions, and for the implementation of alternative strategies as necessary to demonstrate substantial improvement over time.

Pursuant to CMS Guidance, DIDD shall develop Quality Improvement Projects (QIPs) for all systemic issues. QIPs shall be reported in a frequency and format developed by DIDD and approved by TennCare.

#### **Statewide Continuous Quality and Improvement**

- A.33. The Contractor shall collect data regarding its discovery, remediation and improvement activities and shall review the data prior to submission to TennCare to ensure its accuracy and completeness. Files/reports that shall be provided and the schedule by which they must be received are set forth below. A file/report that is determined to be inaccurate or incomplete in any respect shall not be deemed "received" until such deficiency has been corrected.



- a. The Individual Findings File (Flat File) shall provide all of the raw data regarding discovery activities (i.e., findings) for each performance measure and remediation (i.e., corrective actions) and shall be stratified by Waiver program unless otherwise stipulated in the approved Waiver application. The file shall be submitted to TennCare by close of business on the first Friday following the third business day of each month with a one (1) month lag after the reporting period, e.g., the January data is due by the first Friday of March or with a frequency mutually determined by TennCare and the Contractor.
  - b. The Quality Monitoring Report (QMR) shall provide the compliance percentage for each performance measure and the sample size for the reporting period, and shall be stratified by Waiver program, unless otherwise stipulated in the approved Waiver application. The QMR, and related tracking and monitoring, shall be modified as necessary to comport fully with the approved Waivers. The report shall be submitted to TennCare by close of business on the first Friday following the third business day of each month with a one (1) month lag after the reporting period, e.g., the January report is due by the first Friday of March or with a frequency mutually determined by TennCare and the Contractor.
  - c. The Systemic Remediation Report (SRR) shall include a preliminary analysis conducted by DIDD of each performance measure assessed at or below the State's threshold of eighty-five percent (85%) for the reporting period, including an explanation of the issue identified and action steps identified and implemented, as applicable, to address those issues, in a template approved by TennCare. For each deficient performance measure deemed to be "systemic" (which should take into consideration performance across the program year and factors which may have affected performance for the current reporting period), DIDD shall provide an overview of activities undertaken to improve system performance, the efficacy of those efforts, and additional recommendations for systemic improvements that are needed. The report shall be submitted to TennCare by close of business on the first Friday following the third business day of each month with a one (1) month lag after the reporting period, e.g., the January report is due by the first Friday of March or with a frequency mutually determined by TennCare and the Contractor.
  - d. The Mandatory Technical Assistance (MTA) report shall be reported to TennCare each month and shall include, at a minimum, the providers receiving MTA, the reason(s) for receiving MTA, the date MTA started, and a summary of the progress to date. The methodology by which it is determined that the providers shall receive technical assistance shall be documented and available to TennCare upon request.
  - e. The Investigations Report (Number and percentage of DIDD investigations completed within thirty (30) calendar days) shall include all investigations within a given month that were not completed within thirty (30) calendar days and shall include at a minimum the dates each investigation was opened and closed and the reasons for exceeding thirty (30) calendar days. The report shall be submitted to TennCare by close of business on the first Friday following the third business day of each month with a one (1) month lag after the reporting period, e.g., the January report is due by the first Friday of March or with a frequency mutually determined by TennCare and the Contractor.
  - f. DIDD shall provide as expeditiously as possible supporting information as requested by TennCare in its review/validation of these reports. Such information shall be delivered to TennCare in sufficient time to ensure timely delivery of quarterly reports to CMS.
- A.34. The Contractor shall conduct follow-up monitoring activities, and shall offer technical assistance as needed to individual Waiver providers or groups of Waiver providers (which may include all providers, or may be targeted as reflected by QA data, or if requested by TennCare, e.g., geographically, by Waiver service, by Waiver program, by date of enrollment into the Waiver,



etc.) that perform poorly on QA surveys, and shall be responsible for assisting providers improving their performance or for taking necessary corrective actions, including, but not to, recoupments, sanctions, and when a provider is unwilling or unable to comply with W program requirements, termination of participation in the Waiver program.

A list of the providers who perform below "proficient" on QA surveys shall be available to TennCare upon request.

- A.35. The Contractor shall provide the following files/reports in accordance with the schedule set forth below, in addition to the monthly QA files/reports specified above and any other reports that may be requested by TennCare. A file/report that is determined to be inaccurate or incomplete in any respect shall not be deemed "received" until such deficiency has been corrected.
- a. The Waiver Movement Report shall be submitted to TennCare on a monthly basis in a format developed by DIDD and approved by TennCare by the first Friday following the third business day of the month following the reporting period, a one (1) month lag after the reporting period, e.g., the January report is due by the first Friday of March. The report shall include at a minimum:
    - (1) The number of unduplicated participants served in each Waiver during the program year, the number of active participants in each Waiver program, the number of persons, identified by truncated Social Security number enrolled into the Waiver during the month, the number of persons, identified by truncated Social Security number disenrolled from the Waiver during the month, the date of each disenrollment, and the disposition, (e.g., deaths, transition to an ICF/IID, transition to another Waiver program, voluntary disenrollment, involuntary disenrollment), and the reason for such disenrollment if it was involuntary (e.g. death, safety, incarceration, nursing facility stay greater than ninety (90) days, or moved out of state).
    - (2) The number of residents at each Developmental Center, identified by name and truncated Social Security number, the number of admissions, the number of discharges, and the disposition of each discharge, e.g., deaths, transition to another Developmental Center, transition to a smaller state-owned ICF/IID, transition to a private ICF/IID, transition to a community residential Waiver provider, etc.
    - (3) The name and truncated Social Security number of each Waiver participant known to be incarcerated, the date of incarceration, and the location. The Contractor shall cooperate with TennCare's process for checking the status of individuals who become incarcerated.
  - b. Death Reviews
    - (1) A Preliminary Death Review Form documenting, at a minimum, that a death occurred, date, location and the reason for no death review shall be submitted to TennCare within ten (10) business days of receipt into DIDD Central Office in the event a death review is not required, e.g. individual was in hospice care, or the death did not meet criteria of being suspicious, unexpected or unexplained.
    - (2) As the death certificate becomes available it also shall be submitted to TennCare within ten (10) business days of receipt into DIDD Central Office.
    - (3) Regional Death Review Committee Meeting Minutes and/or Reconvene Minutes shall be submitted to TennCare within ten (10) business days of receipt into DIDD Central Office.



- (4) The DIDD Tracking Record that documents any recommendations made Death Review Committee shall include follow up action taken and complete. The DIDD Tracking Record shall be submitted to TennCare on a quarterly basis on the 15<sup>th</sup> of the month following the last month of each quarter or with a frequency mutually determined by TennCare and the Contractor. The Tracking Record shall include only those persons for whom a Death Review was completed.

DIDD shall maintain copies of all death reviews and applicable attachments for ten (10) years for review upon request by TennCare.

- c. The DIDD Organizational Chart shall include, at a minimum, the name, title, and contact information (including office and cell phone, if applicable) for central office and regional office executive and senior staff. The chart shall be submitted to TennCare on an annual basis by the 15<sup>th</sup> of July, with updates regarding any changes delivered within ten (10) business days of the effective date of the change. In addition, DIDD shall submit to TennCare within thirty (30) calendar days of the effective date of this amendment, the resume/vita and brief job description for each currently employed executive staff member, Assistant Commissioner level or higher, with any responsibility pertaining to operation of the Waiver programs, and shall deliver the same to TennCare regarding any new executive staff member, Assistant Commissioner level or higher.

d. Abuse Registry Review Committee:

- (1) The Contractor shall submit a copy of all Substantiated Investigations to be reviewed by the Abuse Registry Review Committee (ARRC) and all applicable attachments to those investigations, including the full version of the Plan of Correction submitted by the provider and approved by DIDD. The Substantiated Investigations shall be submitted to TennCare on a monthly basis at least one (1) week prior to the meeting of the ARRC. The submission shall also include an agenda for the upcoming meeting. Within ten (10) business days following the meeting of ARRC, DIDD shall deliver to TennCare the minutes of the Abuse Registry Review Committee.
- (2) The Contractor shall submit a monthly report summarizing the following information about all substantiated investigations: investigation number, level (if applicable), region, provider name, perpetrator name, type of substantiation (Abuse, neglect, or exploitation) in a format approved by TennCare.
- (3) Plans of Correction: The Contractor shall develop and implement processes to ensure that, prior to receiving the Contractor's approval, the provider's Plans of Correction adequately address the issues contributing to the incident, and identify specific measures to prevent future incidents from occurring, pursuant to CMS Modifications to Quality Measures and Reporting in 1915c Home and Community Based Waivers. The Contractor shall be responsible for ensuring that the procedures outlined in the Plan of Correction have been implemented for protecting the person(s) using services from risk of further abuse, neglect, or exploitation. The Contractor shall hold providers accountable for implementing approved Plans of Correction related to substantiated investigations.
- (4) Incident Management: the Contractor shall develop a comprehensive system to ensure, and demonstrate, that on an ongoing basis the Contractor identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death. The Contractor shall develop a process for identifying and addressing systemic issues related to abuse, neglect, and exploitation and actively preventing future instances; and for evaluating the effectiveness of the state's activities related to those systemic issues.



The Contractor shall be responsible for implementing and maintaining a for tracking and monitoring providers' Substantiated Investigations and to identify providers who show patterns of critical incidents that need to be addressed systemically at the provider level. The Contractor shall hold providers accountable for addressing systemic issues, as identified, and report such actions to TennCare upon request.

- (5) The Contractor shall identify MFP participants in the Incident and Investigation database and shall provide a report to TennCare regarding MFP participants involved in incidents/investigations of alleged abuse, neglect and exploitation. The Contractor shall be responsible for tracking and identifying MFP participants who recur three (3) times or more on the report. The report shall include actions taken to prevent future incidents from occurring. The report shall be submitted to TennCare on a quarterly basis by the 15<sup>th</sup> of the month following the reporting period.
- e. The Annual Financial Accountability Reviews Report shall include at a minimum the name of each agency reviewed during the calendar year, the amount of funding recouped for each agency reviewed, and the total amount of funding recouped during the year. The report shall be submitted to TennCare on an annual basis by the last business day of the first month following the reporting period (i.e., the last business day of January).
- f. The Monetary Sanctions and Recoupments Report shall include at a minimum the name of each agency for which a monetary sanction or recoupment was made, the amount of monetary sanctions for each agency and the amount of recoupments for each agency, and the specific reason for such monetary sanctions and/or recoupments, i.e., the Provider Agreement term, standard, or requirement with which the provider failed to comply. The report shall be submitted to TennCare Director of Intellectual Disability Services and also furnished to the TennCare Director of the Office of Program Integrity on a quarterly basis by the 15<sup>th</sup> of the month following the reporting period, e.g., the first quarter report is due by the 15<sup>th</sup> of April, or with a frequency mutually determined by TennCare and the Contractor.
- g. The Single Person Placements and Transitions Report shall be submitted to TennCare on a quarterly basis by the 15<sup>th</sup> of the second month following the reporting period, e.g., the first quarter report is due by the 15<sup>th</sup> of or with a frequency mutually determined by TennCare and the Contractor.
- h. The Service Recipients over the Individual Cost of Institutional Care Report shall be made available to TennCare upon request.
- A.36. The Contractor shall provide federal, State and TennCare personnel, and its authorized designees and agents, with complete and unrestricted access to all information pertaining to Waiver participants and Waiver program operations, whether paper or electronic, including, but not limited to, all enrollee information received, transmitted, created or maintained by a provider, the Substantiated Investigations, the Client Oriented Survey Management Operating Solutions (COSMOS), and all other current and/or future databases.
- The Contractor shall develop and implement a process for monitoring coordination of benefits with other payer sources, including MCOs and vocational rehabilitation, to ensure no gaps in services and no duplication of services occur. The Waiver is to be the payer of last resort.
- A.37. The Contractor shall ensure that all Waiver providers make available to DIDD complete and unrestricted access to all information pertaining to Waiver participants and Waiver program operations, whether paper or electronic, including, but not limited to, all enrollee information

received, transmitted, created or maintained by a provider, the Substantiated Investigative COSMOS, and all other current and/or future databases.



### **Money Follows the Person (MFP)**

- A.38. The Contractor shall, in accordance with this Interagency Agreement and federal and State laws, regulations, policies and protocols, assist Eligible Individuals living in a Qualified Institution in transitioning to a Qualified Residence in the community under the State's Money Follows the Person (MFP) Rebalancing Demonstration. Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from an ICF/IID, hospital or Nursing Facility (NF) to a DIDD HCBS Medicaid Waiver program pursuant to TennCare and DIDD policies and protocols and shall also be enrolled into MFP.
- A.39. For persons enrolled in a DIDD HCBS Medicaid Waiver program who are also participating in MFP, DIDD shall comply with all applicable provisions of this Interagency Agreement pertaining to the DIDD Waiver programs. This section sets forth additional requirements pertaining to DIDD's responsibilities specifically as it relates to MFP.
- a. Identification of MFP Participants
- (1) DIDD shall identify persons who may have the ability and/or desire to transition from a Qualified Residence, as defined in TennCare protocol, to the community in accordance with TennCare MFP protocols; and shall assess all ICF/IID, hospital and NF residents transitioning to a DIDD HCBS Medicaid Waiver program for participation in MFP in accordance with TennCare MFP protocols.
  - (2) DIDD shall identify a lead staff person for the MFP program and charge that person with overseeing the implementation of the program.
  - (3) DIDD shall be responsible for overseeing operational procedures related to MFP, including, at a minimum: identification of eligible individuals, enrollment, and tracking of participation throughout the MFP program for each individual enrolled in MFP for up to two (2) years following transition to the community for purposes of facilitating the Quality of Life surveys, per the MFP Operational Protocol. A list of the roles and responsibilities, as operationalized by DIDD, will be provided to TennCare upon request.
  - (4) The Contractor shall submit the list of viable candidates for MFP, known as the Candidate ID Report, to TennCare within two (2) business days of the addition of a new candidate.
  - (5) DIDD shall hold training for all DIDD staff implementing the MFP program at least annually and more frequently as needed (e.g., as key staff turnover). The content of the training must be submitted to TennCare at least five (5) business days in advance of the training and is subject to TennCare approval.
  - (6) DIDD shall be responsible for training Independent Support Coordinators (ISCs) about the MFP program, and their responsibilities in the MFP program as ISCs, at least annually or more frequently as needed.
  - (7) DIDD is responsible for transition planning and execution of that plan for individuals transitioning from an institutional setting into a DIDD Waiver, including coordination with MCOs during transition, as appropriate, and according to TennCare protocol.
  - (8) A person may only elect to participate in MFP prior to the person's transition from the ICF/IID, hospital or NF to the community. Once a person has already transitioned to the community, he/she is not eligible to be enrolled in MFP.



b. Eligibility/Enrollment into MFP

- (1) Participation in MFP is voluntary. ICF/IID, hospital and NF residents may consent to participate in MFP or may withdraw consent to participate in MFP at any time without affecting their enrollment in the specified DIDD HCBS Medicaid Waiver program.
- (2) If a person withdraws from MFP, he/she cannot participate in MFP again without meeting the eligibility requirements for enrollment into MFP (e.g., following a ninety (90) day stay in a Qualified Institution).
- (3) The resident's case manager or ISC, or, if DIDD elects to use transition teams, a person who meets the qualifications of a case manager or ISC, shall, using information provided by TennCare, provide each potential MFP participant with an overview of MFP and answer any questions the participant has. DIDD shall, per TennCare MFP protocols have each potential MFP participant or his/her conservator or guardian, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by and documenting the person's decision regarding MFP participation.
- (4) Once a potential MFP participant has consented to participate in MFP, the DIDD designated regional staff person shall notify TennCare within two (2) business days via TPAES as directed by TennCare and per MFP protocols and shall maintain supporting documentation as specified by TennCare that shall be made available to TennCare upon request.
- (5) Final determinations regarding whether a person can enroll into MFP shall be made by TennCare.
- (6) The Contractor shall develop policies and procedures to ensure that each eligible individual is assessed for enrollment in the MFP program. DIDD shall be responsible for maintaining expertise about the MFP program among staff who are responsible for assessing MFP eligibility and discussing MFP with eligible individuals and their families, including but not limited to: Intake staff, case managers and ISCs.

The Contractor shall ensure that all providers and participants in the individuals Circle of Support are aware of the individual's participation in MFP, including an overview of the program and the expectations of the ISC/Case managers (see Sections A.39.c.(3), A.39.c.(5) and A.39.d.(1) – (2) below)

- (7) The Contractor shall, per TennCare MFP protocols, have each potential MFP participant or his/her conservator or guardian, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by DIDD and documenting the person's decision regarding MFP participation. The signed form must be kept on file and submitted to TennCare upon request.

c. Participation in MFP

- (1) The participation period for MFP is three hundred sixty five (365) days. This includes all days during which the person resides in the community, regardless of whether DIDD HCBS are received each day. Days are counted consecutively except for days during which the person is admitted to an inpatient facility for reasons other than respite.
- (2) MFP participation will be "suspended" in the event a person is re-admitted for a short-term inpatient facility stay. The MFP enrollee will not have to re-qualify for MFP regardless of the number of days the person is in the inpatient facility, and



shall be re-instated in MFP upon return to a Qualified Residence in the community.

- (3) The ISC or case manager, as appropriate shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the person are sufficient to safely meet his needs in the community such that continued participation in the DIDD HCBS Medicaid Waiver and in MFP is appropriate. The assessment shall be documented and provided to TennCare upon request.
- (4) DIDD shall notify TennCare within five (5) business days any time a person is admitted to an inpatient facility. Such notification shall be made via TPAES unless otherwise directed by TennCare. DIDD shall maintain supporting documentation as specified by TennCare that shall be made available to TennCare upon request.
- (5) The person's MCO, ISC, transition team or case manager, as appropriate shall be involved in discharge planning on behalf of any MFP participant admitted to an inpatient facility. The involvement shall be documented and available to TennCare upon request.
- (6) DIDD shall notify TennCare within two (2) business days when an MFP participant is discharged from a short-term stay in an inpatient facility. Such notification shall be made via TPAES and shall include whether the person is returning to the same Qualified Residence in which he lived prior to the inpatient stay, or a different residence which shall also be a Qualified Residence.
- (7) DIDD shall track the person's residency throughout the three hundred sixty-five (365)day MFP participation period. In addition, the Contractor shall, for purposes of facilitating completion of Quality of Life surveys, continue to track MFP participants' residency for two (2) years following transition to the community which may be up to one (1) year following completion of the MFP participation period, or until the person is no longer enrolled in a DIDD HCBS Waiver program.
- (8) DIDD shall, using a template provided by TennCare, issue a written notice of MFP participation to each person enrolled in MFP which shall not occur prior to transition from an ICF/IID to DIDD HCBS Medicaid Waiver program. Such notice shall be issued within ten (10) business days as of the date the MFP enrollment is populated into the DIDD-MFP queue in TPAES.
- (9) DIDD shall, using a template provided by TennCare, issue a written notice to each person upon conclusion of the 365-day participation period. Such notice shall be issued within ten (10) business days of the MFP participation end date being populated into the DIDD-MFP queue in TPAES.
- (10) A person who successfully completes three hundred sixty-five (365)day participation period for MFP and is subsequently re-institutionalized may qualify to participate in MFP again in accordance with TennCare MFP Suspended Status and Re-Enrollment protocol.

d. Plan of Care (Individualized Service Plan, ISP)

- (1) For persons participating in MFP, the ISP shall reflect that the person is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from ICF/IID, hospital or nursing facility to DIDD HCBS Medicaid Waiver program).
- (2) Upon conclusion of the person's three hundred sixty-five (365) day participation



period in MFP, the ISP shall be updated to reflect that he is longer partic MFP.

e. Services

- (1) A person enrolled in MFP shall be simultaneously enrolled in the DIDD Statewide HCBS Waiver, the CAC (formerly Arlington) Waiver or the Self-Determination Waiver and shall be eligible to receive covered benefits pursuant to each Waiver application and this Interagency Agreement .
- (2) A person enrolled in DIDD HCBS Waiver services and MFP may be eligible for a Transitional Allowance to assist the participant with expenses associated with transitioning from an ICF/IID, hospital or nursing facility into the community.
- (3) DIDD shall establish policies and procedures for the Transitional Allowance to include:
  - i. A list of goods and services appropriate for purchase with transitional allowance funds;
  - ii. Methodology that will be implemented to assess need for use of transitional allowance funds; and
  - iii. Process to be utilized for request and approval of eligible goods and services.
- (4) DIDD shall utilize process prescribed by TennCare for requesting, billing and payment of eligible goods and services.
- (5) Transitional allowance funds shall only be available during the participant's three hundred sixty-five (365) day participation period of the demonstration. DIDD shall not submit requests for transitional allowance funds after participant has completed the three hundred sixty-five (365) day participation period of the demonstration or upon subsequent MFP occurrences.

f. Continuity of Care

- (1) Upon completion of a person's three hundred sixty-five (365) day participation in MFP, services (including DIDD HCBS Waiver) shall continue to be provided in accordance with the covered benefits and the person's plan of care.
- (2) Transition from participation in MFP and DIDD HCBS Waiver to participation only in DIDD HCBS Waiver shall be seamless to the person, except that the Contractor shall be required to issue notice to the participant of the person's conclusion of his/her three hundred sixty-five (365) day MFP participation period.

A.40. The Contractor shall be responsible for all marketing services relating to this Interagency Agreement and shall submit to TennCare for prior written approval all of its marketing plans, procedures and materials relating to services to be provided including, but not limited to, brochures, fliers, and descriptions of proposed marketing approaches. Approval shall be provided by TennCare within thirty (30) days of receipt of request for approval. Marketing materials must be clear and must include at a minimum a description of the benefits, hours of service available, address of offices, telephone numbers for emergencies, enrollment and disenrollment rights.

A.41. The Contractor's program integrity responsibilities are as follows:

- a. DIDD shall submit all draft submissions and supporting documents related to suspected financial fraud/abuse to TennCare Program Integrity (TennCare PI) and include the projected date of the next scheduled DIDD Fiscal Accountability Review (FAR) or DIDD



Quality Assurance (QA) survey. The referral submissions will apply to findings re only to billing. At least thirty (30) days prior to the projected FAR review or QA si date, DIDD will confer with TennCare PI about whether to continue with the plan... review/survey or to defer until a later date. If TennCare PI does direct DIDD to defer the planned QA survey/FAR review until further notice, then TennCare PI will provide to DIDD documentation in writing of that request.

- b. Screening and Enrollment. Contractor shall require all new providers and providers renewing/re-validating contracts to register with TennCare utilizing TennCare's electronic registration system. All necessary information required for screening and enrollment of all Billing Providers and Ordering and Referring Providers as required by Federal law in 42 C.F.R. §§ 455.410 and 455.450 will be collected during the electronic registration process. Contractor shall review this information for accuracy, completeness, and appropriateness. Once all provider information has been validated, the Contractor shall submit the provider's electronic registration information to the TennCare Provider Registration Unit via the TennCare electronic provider registration system. TennCare shall issue the appropriate TennCare Provider ID number upon successful completion of the screening and enrollment process. In the event that the federal regulations require a site visit for a particular provider as part of the screening process, Contractor shall make the required site visit. Contractor shall not accept claims for payment from any Billing Provider or Ordering and Referring Provider unless the Provider has a valid TennCare Provider ID number. A prescription is considered to be an "order" under Federal regulations. Therefore, no prescription shall be filled unless the prescribing physician has enrolled with the TennCare program. A pharmacist shall supply the TennCare enrollee with a three (3) day supply of a prescription pursuant to the *Grier* Consent Decree provisions. A referral to a specialist for evaluation or treatment is not considered a "referral" subject to the enrollment requirement. Therefore, a provider referring to a specialist need not be enrolled as a TennCare provider.

c. Investigation and Cooperation Requirements:

- (1) The Contractor shall report all possible fraud and abuse to TennCare Program Integrity in the form and manner as directed by TennCare Program Integrity and the appropriate agency as follows.
  - i. All possible enrollee fraud and abuse shall be reported immediately to the Tennessee Office Of Inspector General (OIG)
  - ii. All possible provider fraud and abuse shall be reported immediately to TennCare Program Integrity and Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU):
  - iii. Possible fraud and abuse by the Contractor in the administration of the program shall be reported to TennCare
- (2) Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting possible fraud or abuse, the Contractor shall not take any of the following actions as they specifically relate to TennCare claims, except to institute a corrective action plan after consultation with TennCare Program Integrity:
  - i. Contact the subject of the investigation about any matters related to the investigation;
  - ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
  - iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.



Section 2, above, applies even if the source of the reported activity is an audit or investigation done by another State or Federal agency (i.e. Comptroller, licensing agency) as these investigations or audits often have Program Integrity implications.

The Contractor shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

- (3) The Contractor shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the Contractor shall fully comply with the Tenn. Code Ann. § 71-5-2601 and § 71-5-2603 in performance of its obligations under this Interagency Agreement.
- (4) Contractor shall meet on at least a quarterly basis with the TennCare Office of Program Integrity, and other agencies as necessary to coordinate the program's program integrity work.

d. Records Requirements

- (1) **Records Retention.** A TennCare record is any record, in whatever form, including, but not limited to, medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution. The Contractor, as well as, its subcontractors and providers shall maintain TennCare records necessary to demonstrate that covered services were provided in compliance with state and federal requirements. An adequate record system shall be maintained and that all records be maintained for six (6) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to Tenn. Code Ann. § 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions)
- (2) **Enrollee Records-Consent.** As a condition of participation in TennCare, enrollees or their legal representatives, shall give TennCare, the Comptroller, and any health oversight agency, such as OIG, TBI MFCU, HHS OIG, and the Department of Justice (DOJ), and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and the Comptroller personnel, including, but not limited to, OIG, the TBI MFCU, the HHS OIG, and the DOJ.
- (3) **TennCare Records-Access.** TENNCARE, HHS OIG, the Comptroller, OIG, TBI MFCU, DOJ, and their authorized agents, as well as any authorized state or federal agency or entity shall have the right to access through inspection, evaluation, review or request, whether announced or unannounced, or other means any TennCare records pertinent to this Agreement including, but not limited to, medical records, billing records, financial records including 1099 forms, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution. Such evaluation, inspection, review or request, and when performed or requested, shall be performed with the



immediate cooperation of the provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the requesting agency. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records at no cost to the requesting agency. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records at no cost to the requesting agency. Contractor acknowledges that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to TennCare, OIG, TBI, MFCU, HHS OIG and DOJ and their authorized agents. Any authorized state or federal agency or entity, including, but not limited to, TennCare, OIG, TBI MFCU, HHS OIG, DOJ, the Comptroller, may use these records and information for medical audit, medical review, utilization review and administrative, civil or criminal investigations and prosecutions.

- e. Reporting Requirements. Contractor will prepare monthly and quarterly Program Integrity Activity reports in a form and manner to be established by TennCare Program Integrity. Contractor shall generate ad hoc reports as requested by TennCare as needed in support of TennCare's program integrity functions.
- f. Claims Attestation. Per 42 C.F.R. § 455.18 and § 455.19, the following statement shall be included in any Agreement that the Contractor has with its subcontractors and/or providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."
- g. False Claims Act. The Contractor and its subcontractors and providers shall comply with the provisions of 42 U.S.C. § 1396a(a)(68) *et seq.* as applicable, regarding policies and education of employees as regards the terms of the False Claims Act and whistleblower protections.
- h. Return of Overpayments. In accordance with the Affordable Care Act and TennCare policy and procedures, the Contractor and its subcontractors and providers shall report overpayments and, when it is applicable, return overpayments within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law.
- i. The Contractor shall have surveillance and utilization control programs and procedures (42 C.F.R. §§ 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.
- j. The Contractor, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. Part 455) on disclosure reporting. Contractor shall require that all provider entities that bill and/or receive TennCare funds as the result of this Interagency Agreement shall submit routine disclosures in accordance with timeframes specified in 42 C.F.R. Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request.
- k. The Contractor, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. All provider entities that bill and/or receive TennCare funds as the result of this Interagency Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by



the State and/or the Contractor dependent upon the entity that identifies the payee unallowable funds to excluded individuals.

- i. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act concerning exclusions databases.
- m. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 C.F.R. §§ 455.13, 455.14, 455.21).
- n. The Contractor and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section A.41 of this Interagency Agreement.
- o. The Contractor shall have a written fraud and abuse compliance plan by December 31, 2015. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Interagency Agreement 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 to TennCare as requested by TennCare and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request. The Contractor's fraud and abuse compliance plan shall:
  - (1) Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Interagency Agreement;
  - (2) Include a risk assessment of the Contractor's various fraud and abuse/program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including when financial-related actions (such as overpayment, repayment and fines) are issued on a provider with concerns of fraud and abuse. The Contractor shall inform TennCare of such action and provide details of such financial action. The assessment shall also include a listing of the Contractor's top three (3) vulnerable areas and shall outline action plans in mitigating such risks;
  - (3) Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;
  - (4) Outline activities proposed for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste and on identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;
  - (5) Outline unique policy and procedures, and specific instruments designed to identify, investigate, and report fraud and abuse activities under the HCBS Waiver programs.
  - (6) Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Interagency Agreement;
  - (7) Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
    - i. A list of automated pre-payment claims edits;
    - ii. A list of Fiscal Accountability Reviews on post-processing review of claims;



iii. A list of reports of provider licensing and certification used to aid program payment integrity reviews;

iv. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

v. A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider licensure and certification; and

vi. A list of references in provider and member material regarding fraud and abuse referrals.

(8) Include a list of provisions for the confidential reporting of compliance plan violations to the designated person;

(9) Include a list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;

(10) Ensure that the identities of individuals reporting violations of the Contractor's providers and subcontractors are protected and that there is no retaliation against such persons;

(11) Contain specific and detailed internal procedures for all Contractor's employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

(12) Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU as well as TennCare Office of Program Integrity and that enrollee fraud and abuse be reported to the OIG; and

(13) Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk, as determined by TennCare, to ensure services are rendered and billed correctly.

p. The Contractor shall provide a list of procedures regarding implementation of TennCare policy on disclosure and adverse action reporting.

q. The Contractor shall have provisions in its Compliance Plan regarding the reporting of fraud and abuse activities as required in Section A.41.o.

The Contractor shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against both the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TennCare each month. The Contractor shall establish a method to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.

The Contractor shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of all employees. The Contractor shall establish an electronic database to capture identifiable information on its employees and perform monthly exclusion checking. The Contractor shall provide the State Agency with such database and a monthly report of the exclusion check.

The Contractor shall have provisions in its Compliance Plan regarding prompt terminations of inactive providers due to inactivity in the past twenty-four (24) months.

A.42. The Bureau of TennCare shall be responsible for the following:



- a. promulgate rules for implementation of services under an approved Waiver in accordance with TCA § 4-5-102 et seq., the Tennessee Uniform Administrative Procedures Act.
- b. review all initial Plans of Care (ISP) which shall be submitted with the Pre-Admission Evaluation prior to each participant's enrollment in the Waiver Program.
- c. review, approve, and exercise final administrative authority over all policies and procedures regarding the Waiver Programs. For purposes of this Interagency Agreement, policies and procedures shall include the Provider Manual, all written policies and protocols and training materials pertaining thereto, any additional provider requirements or interpretive guidelines applicable to the Waiver programs, memoranda pertaining to the Waiver programs, and all notices, correspondence and other written materials that will be provided to service recipients, providers, advocates or the public regarding the Waiver programs, including, but not limited to, information regarding eligibility, enrollment, services, and appeal rights. Documents will be reviewed by TennCare as expeditiously as possible but within no more than thirty (30) calendar days of receipt, unless, due to document size, TennCare requires additional time for thorough review.
- d. review and approve any solicitations for services provided or required in the Waiver programs, and all contracts funded in whole or in part with federal dollars prior to the execution of such contracts.
- e. make payment to DIDD in accordance with the methodology specified in C.3.
- f. provide DIDD and/or Providers technical assistance which relates to pertinent statutes, regulations, policies, and procedures affecting the operation of this Interagency Agreement.
- g. demonstrate compliance with federal assurances regarding the health, safety and welfare of Waiver participants through implementation of the Quality Improvement Strategy set forth in the approved Waiver applications, and through utilization review and other monitoring activities that evaluate the performance of DIDD in accordance with this Interagency Agreement.
- h. serve as the liaison or point of contact with CMS regarding all aspects of Waiver Program operations. TennCare shall deliver to CMS and other federal representatives all requested audits and reports pertaining to the Waiver programs. TennCare will copy DIDD on all Waiver -related communications sent to CMS that are not available through the CMS Waiver Applications portal.
- i. review each potential Waiver enrollee's Preadmission Evaluation (PAE) application to establish eligibility for the ICF/IID level of care.
- j. enter approved Preadmission Evaluations (PAEs) in the TennCare MMIS for the purpose of reimbursement for services provided for Waiver recipients.
- k. monitor to ensure that all disenrollments are processed in accordance with all federal, state and TennCare rules and regulations.
- l. review and monitor the Contractor's monthly notification of service recipients who are institutionalized in a hospital, psychiatric hospital, nursing facility, or ICF/IID, as well as progress reports and updates to ensure that Waiver eligibility is terminated when the duration of such institutionalization exceeds ninety (90) consecutive days.



- m. Provide DIDD with each Waiver enrollee's MCO assignment.
- n. Facilitate coordination of benefits by providing DIDD with contact information for the MCOs.
- o. Facilitate a meeting between MCO and DIDD when issues need to be resolved.

A.43. TennCare and DIDD mutually agree to provide the following assurances:

- a. Reporting – Assurance that annually, the agency will provide CMS with information on the Waiver's impact. The information shall be consistent with a data collection plan designed by CMS and shall address the Waiver's impact on:
  - (1) The type, amount, and cost of services provided under the State plan; and
  - (2) The health and welfare of recipients.
- b. Expenditures – Assurance that the average per capita fiscal year expenditures under the Waiver will not exceed the average per capita expenditures for the level of care provided in an ICF/IID under the State plan that would have been made in that year had the Waiver not been granted.

A.44. TennCare and DIDD shall meet on a regularly scheduled basis to review the performance of the activities under this Interagency Agreement and the CMS approved Waiver. TennCare shall notify DIDD in writing of any specific performance deficiencies and request corrective action. DIDD shall respond in writing with a corrective action plan within thirty (30) days of receipt of such notification and implement and monitor the plan upon approval by TennCare.

- a. Should DIDD fail or refuse to undertake corrective action as requested by TennCare, TennCare may withhold payment for that portion of the DIDD program that TennCare deems deficient.
- b. Both Parties agree to cooperate in carrying out the activities described in any applicable Corrective Action Plan mandated by CMS.

A.45. Prior to the effective date of amendments to this Interagency Agreement, as determined by TennCare, the Contractor shall demonstrate to TennCare's satisfaction that it is able to meet the requirements of this Interagency Agreement. The Contractor shall cooperate in a "readiness review" conducted by TennCare to review the Contractor's readiness to meet the requirements of this Interagency Agreement. This review may include, but is not limited to, desk and on-site review of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations (including systems connectivity testing), and interviews with Contractor's staff. The scope of the review may include any and all requirements of this Interagency Agreement as determined by TennCare. Based on the results of the review activities, TennCare will issue a letter of findings and, if needed, will request a corrective action plan from the Contractor.

**B. INTERAGENCY AGREEMENT TERM:**

- B.1. This Interagency Agreement shall be effective on July 1, 2015 ("Effective Date"), and extend for a period of thirty-six (36) months after the Effective Date ("Term"). The Procuring State Agency shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.
- B.2. Renewal Options. This Interagency Agreement may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to two (2) renewal options under the same terms and conditions for a period not to exceed twelve (12) months each by the State, at the



State's sole option. In no event, however, shall the maximum Term, including all renewal extensions, exceed a total of sixty (60) months.

**C. PAYMENT TERMS AND CONDITIONS:**

- C.1. Maximum Liability. In no event shall the maximum liability of the Procuring State Agency under this Agreement exceed Forty Nine Million Four Hundred Twenty Thousand Dollars (\$49,420,000.00) for FY 2016, Forty Nine Million Four Hundred Twenty Thousand Dollars (\$49,420,000.00) for FY 2017, and Forty Nine Million Four Hundred Twenty Thousand Dollars (\$49,420,000.00) for FY 2018, with a total contract maximum liability of One Hundred Forty-Eight Million Two Hundred Sixty Thousand Dollars (\$148,260,000.00). The payment rates in Section C.3 and the Travel Compensation provided in Section C.4 shall constitute the entire compensation due the Contracting State Agency for the goods delivered and accepted or for services performed and all of the Contracting State Agency's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contracting State Agency.
- C.2. Compensation Firm. The payment rates and the maximum liability of the Procuring State Agency under this Agreement are firm for the duration of the Agreement and are not subject to escalation for any reason unless amended.
- C.3. Payment Methodology. DIDD administrative or indirect costs will be billed by DIDD and will be paid by TennCare in accordance with a cost allocation plan approved by the Centers for Medicare and Medicaid Services.
- C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.
- C.5. Payment of Invoice. A payment by the Procuring State Agency shall not prejudice the Procuring State Agency's right to object to or question any payment, invoice, or matter in relation thereto. A payment by the Procuring State Agency shall not be construed as acceptance of any part of the work or service provided or as approval of any amount invoiced.
- C.6. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Procuring State Agency, on the basis of audits conducted in accordance with the terms of this Interagency Agreement, not to constitute proper remuneration for compensable services.
- C.7. Deductions. The Procuring State Agency reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any Interagency Agreement between the Contractor and the Procuring State Agency any amounts, which are or shall become due and payable to the Procuring State Agency by the Contractor.

**D. STANDARD TERMS AND CONDITIONS:**

- D.1. Required Approvals. The Procuring State Agency and the Contracting State Agency are not bound by this Agreement until it is signed by the agency head or the agency head's designee. Each agency's legal counsel shall review and approve the Agreement as to form and legality.
- D.2. Modification and Amendment. Any modifications, amendments, renewals or extensions shall be in writing, signed, and approved by all parties who signed and approved this Agreement.
- D.3. Termination for Convenience. This Agreement may be terminated by either party by giving written notice to the other, at least thirty (30) days before the effective date of termination. Should the Procuring State Agency exercise the option of terminating this Agreement for convenience,



the Contracting State Agency shall be entitled to compensation for all goods delivered and accepted or satisfactory and authorized services completed as of the termination date. If the Contracting State Agency exercise this provision, the Procuring State Agency shall have no liability to the Contracting State Agency except for those goods delivered and accepted or those units of service that were satisfactorily completed by the Contracting State Agency. The final decision as to the acceptability of goods or whether units of service were satisfactorily completed shall be determined by the Procuring State Agency in its sole discretion.

- D.4. Subject to Funds Availability. This Agreement is subject to the appropriation and availability of state and/or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the Procuring State Agency reserves the right to terminate this Agreement upon written notice to the Contracting State Agency. Said termination shall not be deemed a breach of this Agreement by the Procuring State Agency. Upon receipt of the written notice, the Contracting State Agency shall cease all work associated with this Agreement. Should such an event occur, the Contracting State Agency shall be entitled to compensation for all satisfactory and goods delivered and accepted or authorized services completed as of the termination date. Upon such termination, the Contracting State Agency shall have no right to recover from the Procuring State Agency any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- D.5. Completeness. This Agreement is complete and contains the entire understanding between the parties relating to this subject matter, including all the terms and conditions of the parties' agreement. There are no other prior or contemporaneous agreements that modify, supplement, or contradict any of the express terms of the agreement.
- D.6. Communications and Contacts. All instructions, notices, consents, demands, or other communications shall be made in writing and directed to the following designated contact persons:

The Procuring State Agency:

Darin J. Gordon, Deputy Commissioner  
Department of Finance and Administration  
Bureau of TennCare  
310 Great Circle Road  
Nashville, Tennessee 37247-6501  
Telephone # (615) 507-6362  
FAX # (615) 532-5236

The Contractor:

Debra K. Payne, Commissioner  
Citizens Plaza Building  
400 Deaderick street, 10th floor  
Nashville, TN 37243  
Telephone # (615) 532-6533  
FAX # (615) 532-9940 (Fax)

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

- D.7. Termination for Cause. If the Contracting State Agency fails to properly perform its obligations under this Interagency Agreement in a timely or proper manner, or if the Contracting State Agency violates any terms of this Interagency Agreement, the Procuring State Agency shall have the right to immediately terminate the Agreement and withhold payments in excess of fair compensation for completed services.



- D.8. Subcontracting. The Contracting State Agency shall not assign this Interagency Agreement enter into a subcontract for any of the services performed under this Interagency Agreement without obtaining the prior written approval of the Procuring State Agency. Notwithstanding any use of approved subcontractors, the Contracting State Agency shall be the prime contractor and shall be responsible for all work performed.
- D.9. Monitoring. The Contracting State Agency's activities conducted and records maintained pursuant to this Interagency Agreement shall be subject to monitoring and evaluation by the Procuring State Agency, the Comptroller of the Treasury, or their duly appointed representatives.
- D.10. Progress Reports. The Contracting State Agency shall submit brief, periodic, progress reports to the Procuring State Agency as requested.
- D.11. State and Federal Compliance. The Contracting State Agency shall comply with all applicable state and federal laws and regulations in the performance of this Agreement.
- D.12. Headings. Section headings are for reference purposes only and shall not be construed as part of this Agreement.

**E. SPECIAL TERMS AND CONDITIONS:**

- E.1. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the Procuring State Agency or acquired by the Contractor on behalf of the Procuring State Agency shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Interagency Agreement; previously possessed by the Contractor without written obligations to the Procuring State Agency to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the Procuring State Agency's information; or, disclosed by the Procuring State Agency to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the Procuring State Agency or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Interagency Agreement.

- E.2. Lobbying. The Contractor certifies, to the best of its knowledge and belief, that:
  - a. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or



employee of an agency, a Member of Congress, an officer or employee of Congress, an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

- b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Interagency Agreement, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, *U.S. Code*.

E.3. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;
- b. have not within a three (3) year period preceding this Interagency Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and
- d. have not within a three (3) year period preceding this Interagency Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the Procuring State Agency if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified.

E.4. Federal Funding Accountability and Transparency Act (FFATA). This Interagency Agreement requires the Contractor to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:



a. Reporting of Total Compensation of the Contractor's Executives.

- (1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor's preceding completed fiscal year, if in the Contractor's preceding fiscal year it received:
  - i. Eighty percent (80%) or more of the Contractor's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
  - ii. Twenty Five Thousand Dollars (\$25,000,000) or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and
  - iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/excomp.htm>.)

Executive means officers, managing partners, or any other employees in management positions.

- (2) Total compensation means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):
  - i. Salary and bonus.
  - ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
  - iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
  - iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
  - v. Above-market earnings on deferred compensation which is not tax qualified.
  - vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds Ten Thousand Dollars (\$10,000).

- b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Interagency Agreement is awarded.



- c. If this Interagency Agreement is amended to extend its term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the amendment to this Interagency Agreement becomes effective.
- d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Interagency Agreement. More information about obtaining a DUNS Number can be found at: <http://fedgov.dnb.com/webform/>

The Contractor's failure to comply with the above requirements is a material breach of this Interagency Agreement for which the State may terminate this Interagency Agreement for cause. The State will not be obligated to pay any outstanding invoice received from the Contractor unless and until the Contractor is in full compliance with the above requirements.

E.5. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Contractor shall prohibit smoking of tobacco products within any indoor premises in which services are provided pursuant to this Interagency Agreement to individuals under the age of eighteen (18) years. The Contractor shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Interagency Agreement.

E.6. HIPAA Compliance. The State and the Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Interagency Agreement.

- a. The Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable requirements in the course of this Interagency Agreement.
- b. The Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of this Interagency Agreement so that both parties will be in compliance with the Privacy Rules.
- c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and the Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Interagency Agreement is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.
- d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

E.7. Business Associate. Contractor hereby acknowledges its designation as a business associate under HIPAA and agrees to comply with all applicable HIPAA regulations. In accordance with the HIPAA regulations, the Contractor shall, at a minimum:

- a. Comply with requirements of the HIPAA, including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations. Compliance includes meeting all



required transaction formats and code sets with the specified data sharing agreement required under the regulations;

- b. Transmit/receive from/to its providers, subcontractors, clearinghouses and HCFA all transactions and code sets required by HIPAA in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by HCFA so long as HCFA direction does not conflict with the law;
- c. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Interagency Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between HCFA and the Contractor and between the Contractor and its providers and/or subcontractors to a halt, if for any reason the Contractor cannot meet the requirements of this Section, HCFA may terminate this Interagency Agreement.
- d. Ensure that Protected Health Information (PHI) exchanged between the Contractor and HCFA is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations shall be de-identified to secure and protect the individual enrollee's PHI;
- e. Report to HCFA's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Interagency Agreement by the Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;
- f. Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Contractor pursuant to this Section;
- g. Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available upon request to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations;
- h. Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations;
- i. Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted by or on behalf of HCFA agrees to use reasonable and appropriate safeguards to protect the PHI.
- j. If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with this Section of this Interagency Agreement. The Contractor shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. The Contractor shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, the Contractor shall: (1) certify an oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;



- k. Implement all appropriate administrative, physical and technical safeguards to protect the use or disclosure of PHI other than pursuant to the terms and conditions of this In Agreement and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;
  - l. Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
  - m. Create and implement policies and procedures to address present and future HIPAA regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;
  - n. Provide an appropriate level of training to its staff and employees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
  - o. Track training of Contractor's staff and employees and maintain signed acknowledgements by staff and employees of the Contractor's HIPAA policies;
  - p. Be allowed to use and receive information from HCFA where necessary for the management and administration of this Interagency Agreement and to carry out business operations where permitted under the regulations;
  - q. Be permitted to use and disclose PHI for the Contractor's own legal responsibilities;
  - r. Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Contractor's employees and other persons performing work for the Contractor to have only minimum necessary access to PHI and personally identifiable data within their organization;
  - s. Continue to protect and secure PHI and personally identifiable information relating to enrollees who are deceased; and
  - t. Track all security incidents as defined by HIPAA and, as required by the HIPAA Reports. The Contractor shall periodically report in summary fashion to HCFA such security incidents.
- E.8. Information Holders. HCFA and the Contractor are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of Contractor's information system, as defined by TCA 47-18-2107, the Contractor shall indemnify and hold HCFA harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2) and (3), shall only be permitted with HCFA's express written approval. The Contractor shall notify HCFA's Privacy Office immediately upon becoming aware of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.
- E.9. Notification of Breach and Notification of Suspected Breach. - The Contractor shall notify HCFA's Privacy Office immediately upon becoming aware of any incident, either confirmed or suspected, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.



- E.10. All subcontracts must be in writing and fulfill the requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.
- E.11. Procedures Upon Termination. Upon termination of this Interagency Agreement for either convenience or cause, the Contractor shall promptly supply all material necessary for continued operation and payment and related systems, including computer programs, data files, user and operation manuals, system and program documentation, training for Medicaid agency staff, their agents or designated representatives in the operation and maintenance of any systems, and other documentation as requested. In addition, the Contractor shall promptly furnish TennCare all information necessary for the reimbursement of any outstanding Medicaid claims.
- E.12. Authority. If other State or local agencies or offices perform services for TennCare, including the Contractor, these entities do not have the authority to change or disapprove any administrative decision of TennCare, or otherwise substitute their judgment for that of TennCare with respect to the application of policies, rules and regulations issued by TennCare.
- E.13. Applicable Laws, Rules, Policies and Court Orders. The Contractor agrees to comply with all applicable federal and State laws, rules, regulations, sub-regulatory guidance, executive orders, HCFA Waivers, and all current, modified or future Court decrees, orders or judgments applicable to the State's TennCare and CHIP programs. Such compliance shall be performed at no additional cost to the State.
- E.14. The Contractor shall comply and submit to TennCare the disclosure of ownership and control information in accordance with the requirements specified in 42 C.F.R. Part 455, Subpart B, using the form approved by TennCare
- E.15. Disclosure of Personal Identity Information. The Contractor shall report to the State any instances of unauthorized disclosure of confidential information that come to the attention of the Contractor. Any such report shall be made by the Contractor within twenty-four (24) hours after the instance has come to the attention of the Contractor. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals that are deemed to be part of a potential disclosure. The Contractor shall bear the cost of notification to individuals having personal identity information involved in a potential disclosure event, including individual letters and/or public notice.
- E.16. Severability. If any terms and conditions of this Interagency Agreement are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Interagency Agreement are declared severable.
- E.17. Records. The Contractor shall maintain documentation for all charges under this Interagency Agreement. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Interagency Agreement, shall be maintained for a period of six (6) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.
- E.18. Social Security Administration (SSA) Required Provisions for Data Security. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.



- a. The Contractor shall not duplicate in a separate file or disseminate, without prior permission from TennCare, the data governed by the Interagency Agreement for purpose other than that set forth in this Interagency Agreement for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.
- b. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Interagency Agreement.
- c. The Contractor shall provide a current list of the employees of such Contractor with access to SSA data and provide such lists to TennCare.
- d. The Contractor shall restrict access to the data obtained from TennCare to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Interagency Agreement. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining TennCare's prior written approval.
- e. The Contractor shall ensure that its employees:
  - (1) properly safeguard PHI/PII furnished by TennCare under this Interagency Agreement from loss, theft or inadvertent disclosure;
  - (2) understand that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor's employee is at his or her regular duty station;
  - (3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
  - (4) send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and,
  - (5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

Contractor employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Interagency Agreement may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

- f. **Loss or Suspected Loss of Data** – If an employee of the Contractor becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact TennCare **within 1 hour** to report the actual or suspected loss. The Contractor will use the Loss Worksheet located at [http://www.tn.gov/tenncare/forms/phi\\_piiworksheet.pdf](http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf) to quickly gather and organize information about the incident. The Contractor must provide TennCare with timely updates as any additional information about the loss of PHI/PII becomes available.

If the Contractor experiences a loss or breach of said data, TennCare will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.



- g. TennCare may immediately and unilaterally suspend the data flow under this Interagency Agreement, or terminate this Interagency Agreement, if TennCare, discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Interagency Agreement.
- h. Legal Authority – Federal laws and regulations giving SSA the authority to disclose data to TennCare and TennCare's authority to collect, maintain, use and share data with Contractor is protected under federal law for specified purposes:
- (1) Sections 1137,453, and 1106(b) of the Act (42 U.S.C. 1320b-7, 653, and 1306(b)) (income and eligibility verification data);
  - (2) 26 U.S.C. 6103(l)(7) and (8) (tax return. data);
  - (3) Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. 401(x)(3)(B)(iv))(prisoner data);
  - (4) Section 205(r)(3) of the Act (42, U.S.C. 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);
  - (5) Sections 402,412, 421, and 435 of Pub. L. 104-193 (8 U.S.C. 1612, 1622, 1631, and 1645) (quarters of coverage data);
  - (6) Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3 (citizenship data); and
  - (7) Routine use exception to the Privacy Act, 5 U.S.C. 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).

This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 *et seq.*), and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the Contractor must follow with regard to use, treatment, and safeguarding data.

i. Definitions

- (1) "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TennCare).
- (2) "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 CFR 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
- (3) "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- (4) "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial



transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

**E.19. Nondiscrimination Compliance Requirements.**

- a. Contractor agrees that it shall comply with the applicable federal and State civil rights laws and regulations, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and 42 U.S.C. § 18116. As part of this compliance no person on the grounds of handicap and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Contractor's obligation under its agreement with TennCare or in the employment practices of the Contractor.
- b. Contractor agrees that its civil rights compliance staff member will work directly with TennCare's Nondiscrimination Compliance Director in order to implement and coordinate nondiscrimination compliance activities. The Contractor shall provide to TennCare, within ten (10) days of signing this Contract, the name and contact information of its civil rights compliance staff member. If at any time that position is reassigned to another staff member, the new staff member's name and contract information shall be reported in writing to TennCare within ten (10) calendar days of assuming these duties.

**E.20. Assessment of Monetary Sanctions:**

In addition to the remedies described in Section D.7, TennCare may choose to assess Monetary Sanctions (see Attachment A) for each instance in which the Contractor fails to properly perform its obligations as defined under this Interagency Agreement in an appropriate and/or timely manner, including monitoring and oversight of its subcontractor(s) to ensure compliance with this Interagency Agreement. Upon determination that the Contractor has failed to perform one or more of the services described in Section A under this Interagency Agreement in an appropriate and/or timely manner, TennCare will notify the Contractor in writing of the deficiency. The Contractor must work to immediately correct such deficiency. The Contractor shall have ten (10) business days from the date of notification to provide proof that such deficiency has been fully resolved to the satisfaction of TennCare. The Deputy Commissioner of TennCare shall determine when a deficiency has been satisfactorily cured. Resolution of the identified deficiency within ten (10) business days does not preclude TennCare's ability to assess a one-time penalty for each instance of such deficiency.

Should the deficiency remain more than ten (10) business days from notification by the Procuring State Agency, TennCare may impose additional Sanctions for each day that the deficiency remains unresolved and/or satisfactory documentation thereof is not provided to the Procuring State Agency. The Sanctions may be retroactive to the date of notice of deficiency and will be deducted from the monthly payments to the Contractor.

**IN WITNESS WHEREOF:**

**DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES:**

DPayne  
DEBRA K. PAYNE, COMMISSIONER

5/28/15  
DATE



DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION  
BUREAU OF TENNCARE:

*Larry B. Martin*

LARRY B. MARTIN COMMISSIONER

*6/11/2015*

DATE



### ASSESSMENT OF MONETARY SANCTIONS

It is acknowledged by TennCare and the Contractor that in the event of failure to meet the requirements provided in this Interagency Agreement and all documents incorporated herein, TennCare will be harmed. The actual damages which TennCare will sustain in the event of and by reason of such failure are uncertain and are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described below. It is further agreed that the Contractor shall pay TennCare liquidated damages as directed by TennCare and not to exceed the fixed amount as stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Interagency Agreement requirements listed below but for TennCare's failure to perform as provided in this Interagency Agreement, the Contractor shall not be liable for damages resulting directly therefrom.

	<b>PROGRAM ISSUES</b>	<b>SANCTION</b>
1.	Failure to provide each Waiver enrollee an individualized written plan of care which is developed within sixty (60) calendar days of admission. (Section A.12)	\$500.00 per enrollee, per calendar day beyond the 60 <sup>th</sup> day following each enrollee's admission that the individualized written plan of care is not provided
2.	Failure to perform annual reevaluation of the Waiver enrollee's need for continued stay in the Waiver . (Section A.13)	\$1,000.00 per enrollee, per occurrence
3.	Failure to provide TennCare with written notification of any involuntary Waiver disenrollment prior to the actual disenrollment. (Section A.15)	\$1,000.00 per enrollee, per occurrence
4.	Failure to ensure that persons receiving institutional care for a consecutive period of 90 (ninety) days are properly and timely disenrolled from the Waiver (Section A.18)	\$ 100.00 per person, per calendar day that the person remains enrolled in the Waiver beyond the 90 <sup>th</sup> day following that person's admission to the institution
5.	Failure to comply with the notice requirements of the TennCare rules and regulations or any subsequent amendments thereto, and all court orders governing appeal procedures, as they become effective (A.19, A.20)	\$500 per occurrence in addition to \$500 per enrollee, per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Interagency Agreement or required by TennCare
6.	Failure to provide continuation or	An amount sufficient to at least offset



	restoration of services where enrollee was receiving the service as required by the TennCare rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective. (A.20)	any savings the Contractor achieves with withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense, plus \$500 per enrollee, per day for each calendar day beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is not adequately responded to by the Contractor after being sent by TennCare
7.	Failure to forward an expedited appeal to TennCare in twenty-four (24) hours or a standard appeal in five (5) days. (A.20)	\$500 per enrollee, per calendar day that the appeal is not forwarded to TennCare within, or beyond, the applicable time period.
8.	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective. (A.20)	\$500 per enrollee, per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Interagency Agreement or required by TennCare.
9.	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective. (A.20, A.30)	<p>First occurrence: \$500 per instance of such "systemic problems or violations of the law", even if sanctions regarding one or more particular instance(s) have previously been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, plus \$500 per each separate defective notice sent to each enrollee even if a corrected notice was issued upon request by TennCare)</p> <p>Sanctions per instance of such "systemic problem or violation of the law" shall increase in \$500 increments for each subsequent "systemic problem or violation of the law" (\$500 per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; \$1,000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.) plus \$500 per each separate defective notice sent to each enrollee even if a corrected notice was issued upon request by TennCare.</p>
	Failure to deliver an accurate and	\$500.00 per file or report plus \$100 for



10.	complete file or report timely (Sections A.33, A.35, and A.41)	each calendar day that the file is not received, or is inaccurate or incomplete.
11.	Failure to remediate an individual finding within thirty (30) days of discovery or to document such remediation in an accurate and complete manner ( A.32)	\$500 per occurrence plus \$100 for each calendar day beyond thirty (30) days that the finding is not remediated, or for which documentation of such remediation is inaccurate or incomplete.
12.	Failure to take appropriate actions to remediate systemic issues (A.32)	\$5,000 per performance measure for which the compliance percentage remains consistently at or below 85% and for which DIDD cannot demonstrate diligent and varied actions that could be reasonably anticipated to yield substantial improvements in system performance
13.	Failure by the Contractor to ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of TennCare enrollee PHI. (E.6, E.18)	\$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by Contractor's failure to comply with the terms of this Interagency Agreement, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services
14.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (E.6)	\$500 per enrollee per occurrence
15.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (E.9)	\$500 per enrollee per occurrence, not to exceed \$10,000,000
16.	Failure to provide a service or make payments for a service within five (5) calendar days of a directive from TennCare to do so or upon approval of the service or payment by the Contractor during the appeal process, or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause.	\$500 per enrollee, per calendar day, beginning on the next calendar day after default by the Contractor in addition to the cost of the services not provided.
17.	Failure to provide proof of compliance	\$500 per enrollee, per calendar day,



	to the TennCare Office of Contract Compliance and Performance within five (5) calendar days of a directive from TennCare or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause.	beginning on the next calendar day in default by the Contractor.
18.	Failure to submit a timely corrected notice of adverse action to TennCare for review and approval prior to issuance to the member.	\$1000 per occurrence if the notice remains defective, plus a per enrollee, per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective, or is not submitted to TennCare as required.
19.	Failure to either 1) provide an approved service timely, i.e. in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver or Attachment III, or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service.	The cost of services not provided plus \$500 per enrollee, per calendar day, for each day 1) that approved care is not provided to an enrollee timely; or 2) notice of delay is not provided to the enrollee and/or the Contractor fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service. In the event the Contractor fails to provide both services and notice of delay, this damages amount may increase to \$1,000 per enrollee, per calendar day, at TennCare's option.
20.	Failure to perform in an appropriate and/or timely manner any of the other services described in Section A Scope of Services in this Interagency Agreement not specified in items 1 – 19 above.	\$100 per occurrence, plus \$100 per calendar day for each day that the deficiency remains unresolved and/or satisfactory documentation thereof is not provided to TennCare. If the failure involves individual enrollees, this amount may be calculated at TennCare's option at the rate of \$100 per occurrence, plus \$100 per enrollee, per calendar day that the deficiency remains or satisfactory documentation is not provided.
21.	Failure to adhere to the individual cost neutrality cap by approving an Independent Support Plan in the Statewide Waiver that is in excess of the individual cost cap. (A.26)	\$5,000 per enrollee, per occurrence.