STATE OF TENNESSEE
Department of Finance and Administration, Division of TennCare

REQUEST FOR PROPOSAL # 31865-00633
AMENDMENT #2 FOR FISCAL EMPLOYER AGENT

DATE: December 1, 2022

RFP # 31865-00633 IS AMENDED AS FOLLOWS:

1. **This RFP Schedule of Events updates and confirms scheduled RFP dates.** Any event, time, or date containing revised or new text is highlighted.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		September 20, 2022
2. Disability Accommodation Request Deadline	2:00 p.m.	September 23, 2022
3. Pre-response Conference	1:00 p.m.	October 3, 2022
4. Notice of Intent to Respond Deadline	2:00 p.m.	October 5, 2022
5. Written "Questions & Comments" Deadline	2:00 p.m.	October 20, 2022
6. State Response to Written "Questions & Comments"		December 1, 2022,
7. Response Deadline	2:00 p.m.	December 21, 2022
8. State Completion of Technical Response Evaluations		January 25, 2023
9. State Opening & Scoring of Cost Proposals	2:00 p.m.	January 27, 2023
10. Negotiations (optional)		January 31, 2023, through February 2, 2023
11. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection		February 16, 2023
12. End of Open File Period		February 23, 2023
13. State sends contract to Contractor for signature		February 28, 2023
14. Contractor Signature Deadline		March 15, 2023

2. State responses to questions and comments in the table below amend and clarify this RFP.

Any restatement of RFP text in the Question/Comment column shall NOT be construed as a change in the actual wording of the RFP document.

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
1.		General	Who is the current Fiscal Employer Agent? What is the term of the current Fiscal Employer Agent contract?	Public Partnership, LLC - https://www.tn.gov/content/dam/tn/tenncare/documents2/PublicPartnerships56969.pdf Current Term: December 1, 2017, to December 31, 2022. This contract is pending amendment execution for extension to June 30, 2023. Morning Sun Financial Services – https://www.tn.gov/content/dam/tn/tenncare/documents2/MorningSun71808.pdf Current Term: September 1, 2011, to December 31, 2022. This contract is pending amendment execution for extension to June 30, 2023.
2.		General	Will the current the Fiscal Employer Agent's responsibilities include turning over their contract to the new Fiscal Employer Agent?	The current FEAs shall assist with the transition to a new FEA. See Contract Sections E.28 and E.29: https://www.tn.gov/content/dam/tn/tenncare/documents2/PublicPartnerships56969.pdf See Contract Sections E.25 and E.26: https://www.tn.gov/content/dam/tn/tenncare/documents2/MorningSun71808.pdf
3.		General	What is the current Fiscal Employer Agent fee schedule?	Financial Administration - $80.00 Per Participant Per Month (PMPM) Support Brokerage - $105.00 PMPM Set-up for New Consumer Direction or Self Direction Referral - $95 Per Participant Set-up for New Worker - $125.00 Per Worker
4.		General	Are program services billed as units or as dollars?	Services are billed as units.
5.		General	Please provide the current number of Participants and workers for each of the TennCare Medicaid programs and authorities, including the TennCare CHOICES in Long-Term Services and Supports Program	Number of Workers as of September 2022: CHOICES – 2,870 ECF CHOICES – 1,150 Katie Beckett – 256

			(CHOICES), Employment and Community First CHOICES Program (ECF CHOICES), the Section 1915(c) HCBS Waiver Programs, and the Katie Beckett Programs.	SDW - 661 Number of Participants as of September 2022: CHOICES – 2247 ECF CHOICES – 1030 KB – 130 SDW - 563
6.	1	1.1.2	What is the average funding amount required per payroll including all employer related costs?	For ECF CHOICES, KB, and CHOICES the average administrative cost is $704,720 per month. The average payroll per pay period is $1,468,003.
7.	1	1.1.2	What is the average funding amount required per month including all employer related costs?	See response to Question 6.
8.	2/7	1.4.5/3.2	RFP Section 1.4.5 states, "It is encouraged for Respondents to submit bids digitally."; while RFP Section 3.2 Response Delivery states a hard copy of the Technical and Cost Proposals with digital copies. Please clarify which requirement is correct, all digital or hardcopy and digital.	Yes, email proposals can be submitted to the Solicitation Coordinator. See revised RFP Section 3.2, Response Delivery below. Please see item #4 below.
9.	2/47/48	2./Contract B./Contract C.3	For this question let's assume the State's projected date are actual dates. The Schedule of Events states the Contractor Signature Deadline is March 1, 2023, the contract states "The contract shall be effective on April 1, 2023, and the contractor compensation table states July 1. 2023. Using these dates should bidders assume they will begin work on April 1, 2023 and must start the Fiscal Employer Agent services on July 1st?	Yes.
10.	2/47/48	2./Contract B./Contract C.3	The four-month Transition will require the availability and cooperation or the incumbent vendor and the Department. Can bidders assume the incumbent vendor and Department will have the necessary staff and availability to meet their tasks assignments?	Yes
11.	6	3.1.1	Where in the Technical Response should a bidder submit RFP 31865-00633 Statement of Certifications and Assurances and Attachment C – Attestation RE Personnel Used in Contract Performance?	Attachment C is not a requirement for the proposal submission. Attachment C will be required for completion of the awarded contractor upon the State's request for signature of the contract agreement.
12.	6	3.1.1.3	"All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations." We assume a Table of Contents, Cover Letter or Executive Summary, or appendices containing additional	Correct.

			information providing an example for a 6.2 response are not concerned "extraneous". Please confirm.	
13.	13	5.2	Could an oral presentation with a solution demonstration be part of the evaluation process?	Oral Presentations are not required for RFP 31865-00633.
14.	15	5.3	Will unsuccessful bidders also be notified of the Notice of Intent to Award? Will evaluation scores be part of the Notice?	Yes, all parties that submitted a response to RFP 31865-00633 are notified of the Notice of Intent to Award. All evaluation documentation will be available for review during the 7-day Open File Period specified in the RFP Schedule of Events upon request.
15.	15	5.3.3	" …make the RFP files available for public inspection..." Our proposal will contain confidential and proprietary information, which if released could adversely affect our business. Can bidders submit a redacted version of the Technical proposal, which would be used for public inspection? If so, please provide instructions for submitting a redacted Technical proposal.	The State does not accept redacted proposals. Please refer to RFP Section 4.8 Disclosure of Response Contents.
16.	17-26	Attachment 6.2 Sections A, B & C	Does the State have a preference where the RFP Section A, B and C requirements with Proposal page numbers are located in the Proposal for the evaluators? For example, should the RFP Sections A, B & C requirements be located together at the front of the proposal or would the evaluators prefer to have each Section requirement be located in front of the specific Section Proposal responses?	There is no specific order by which the respondent is to organize the response proposal for Sections A, B, and C. Both options presented in the question are acceptable. It is recommended that the respondent provide the Response Page # for Sections A, B, and C in the first column for the applicable Sections for reference.
17.	19	B6	We assume the "acquisitions" is referring to the purchase of the bidder company and not the bidder company acquiring companies. Please confirm.	"Acquisitions" applies to both scenarios
18.	24	C.3.2	Has each program determined the process for the transition of existing Participants to the selected vendor? If so, please provide the process for each program.	This process will be dependent upon the selected vendor and systems.
19.	24	C.3.2	Will each Worker need to requalify during the Implementation Phase, or will the requalification requirements be met prior to their existing expiration date? If requalification is required prior to their expiration date how will the contractor be provided with expiration dates?	No workers will need to re-qualify to continue serving a member. The implementation of this contract will not delay or impact the provision of services or payment to workers.
20.	24	C.3.10	Will each existing Worker need to have their qualifications recertified as part of the transition to the selected vendor?	No
21.	27	Cost Proposal	The evaluation factor (members) is the same for June 1, 2023 – May 31, 2026. Are the member numbers the current number of	No, the projected number of members is not expected to remain stagnant. We will be implementing consumer direction in two additional 1915(c) waivers in CY2023.

		& Scoring Guide	members? If not Please provide the projected number of Participants and workers for each of the TennCare Medicaid programs and authorities, including the TennCare CHOICES in Long-Term Services and Supports Program (CHOICES), Employment and Community First CHOICES Program (ECF CHOICES), the Section 1915(c) HCBS Waiver Programs, and the Katie Beckett Programs.	Approximately 5,000 members are in these waivers. The projected number of participants is 5,750 each year for all programs. The projected number of workers is 7,261. For additional context, participation in CD for the CHOICES programs has remained at an average of 2250 since September 2020, while enrollment in ECF CHOICES and subsequent participation in CD has increased to an average of 910 in CY2022. The Self-Determination waiver is closed to new enrollment and thus, we expect that CD participation will decline as the population in this waiver declines. However, we anticipate making consumer direction available to the approximately 5,000 members in the Statewide and Comprehensive Aggregate Cap waivers in 2023.
22.	27	Cost Proposal & Scoring Guide	The evaluation factor (members) is the same for June 1, 2023 – May 31, 2026. Does the State believe the number of members will not change during this time frame?	See response to #21 above
23.	27	Cost Proposal & Scoring Guide	How and by whom will the actual number of members be determined each month?	MCOs in collaboration with the FEA will establish a process that allows for the efficient exchange of all relevant member information regarding members electing to participate in consumer direction between the MCO and the FEA.
24.	27	Cost Proposal & Scoring Guide	The evaluation factor (members) is the same for June 1, 2026 – May 31, 2028 are less than the number of members cited for the base contract. Does the State believe the number of members will reduce rather than increase? Please explain.	See response to #21 above
25.	27/48	Cost Proposal & Scoring Guide	The Cost Proposal Table for the base contract dates is June 1, 2023 – May 31, 2026 and the Optional Years dates are June 1, 2026 – May 31, 2028 while the contact dates for the base proposal are July 1, 2023 – June 30, 2026, and the Optional Years date is July 2026 – June 30, 2028. Please explain the differences.	The Cost Proposal table in RFP Attachment 6.3 is adjusted to align with RFP Attachment 6.6, Pro Forma Section C.3. Please see item #3 below.
26.	29	Reference Questionn aire	Please confirm that a minimum of three (3) "References from at least three (3) different individuals" to a maximum of five (5), "two (2) contracts Respondent currently services that are similar in size and scope to the services required by this RFP; and three (3) completed contracts that are similar in size and scope to the services required by this RFP." are required.	References are not a requirement for the submission of a response to the RFP. There is no evaluation criteria or disqualifying criteria included in the RFP applicable to the submission of references.

27.	4	Contract A.11.c	"…if an individual requests that the Contractor mail them a copy of the material/information, the Contractor must mail free of charge the material/information…". Please provide the number of mailings made in the past 12 months.	87,446 total mailings
28.	5	Contract A.11.d	". All Contractor's Vital Documents shall be translated and available to each Limited English Proficiency group identified by TennCare, that constitutes five percent (5%) of the TennCare population, or one thousand (1,000) enrollees, whichever is less;" Please provide the additional languages that would be needed to meet this requirement.	At your request below is a list of the top 32 LEP languages in Tennessee and we have included a list of the top eleven (11) language and communication assistance requests for State Fiscal Year 21-22 in this list. TennCare adopted HHS' Guidance to Federal Financial Assistance ("FFA") Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting LEP Persons as its official LEP policy. This HHS guidance discusses large programs, like TennCare, that regularly serve LEP persons who speak dozens and sometimes over 100 different languages. With large programs, the extent of the recipient's obligation to provide written translations of documents may be determined by the recipient on a case-by-case basis, looking at the totality of the circumstances in light of the four-factor analysis and recipients may utilize HHS' safe harbor provisions. Therefore, TennCare's Office of Civil Rights Compliance's expectation is that Contractors provide vital documents at a minimum in Spanish and Arabic and these vital documents can be translated into any other language upon request by the member. TOP 32 Limited English Proficient Languages in Tennessee 2013-2017 Data (in no particular order) 1. Spanish – 248,552 2. French – 10,931 3. Haitian – 1,875 4. Italian – 2,276 5. Portuguese – 2,391 6. German – 12,233 7. Yiddish – 3,647 8. Russian – 4,305 9. Polish – 1,175 10. Serbo-Croatian – 1,130 11. Ukrainian – 1,776 12. Persian (including Farsi, Dari) – 3,261 13. Gujarati – 5,903 14. Hindi – 5, 610 15. Urdu – 2,570 16. Bengali – 1,398 17. Nepali – 4, 456 18. Telugu – 4, 015 19. Tamil – 2,015 20. Malyalam, Kannada, Dravidian – 1,977 21. Chinese – 14, 774 22. Japanese – 4,341 23. Korean – 8,417

				24. Vietnamese – 9, 718 25. Khmer – 1,535 26. Thai, Lao – 6,920 27. Tagalog – 7,298 28. LLocano, Samoan, Hawaiian – 2, 135 29. Arabic – 23,463 30. Amharic, Somali – 6,039 31. Yoruba, Twi Igbo – 5,699 32. Swahili – 3,601 TennCare population data for SFY 21-22 top language and communication assistance requests: 1. Spanish – 78,632 2. Arabic – 3,383 3. Vietnamese – 702 4. Korean - 470 5. English Large Print – 461 6. Chinese Mandarin – 370 7. American Sign Language – 333 8. Swahili - 242 9. Chinese - 238 10. Burmese – 237 11. Nepali - 205
29.	8	Contract A.20	"…generally limited to the information that the potential Worker voluntarily provides on any applicable Worker paperwork and does not require the Contractor to perform any further investigation or inquiry…" How is the contractor required to "determine" if the qualified Worker is a family member?	The member or employer of record must attest that the qualified worker meets all requirements, understanding that a violation in any of the requirements is considered fraud.
30.	11	Contract A.25.e	Please provide a list and sample of each applicable State forms.	Current program documents can be found here: https://www.publicpartnerships.com/state-programs/tennessee/ However, changes to these forms may be made during the transition to a new vendor.
31.	19	Contract A.45	Would the State consider increasing the member caseload limit above the 50:1 ratio if the bidder can demonstrate the use of technologies increases a Support Broker capabilities with examples of other clients' Support Broker capabilities?	Not initially. The state may be open to further discussion with the future contractor.
32.	19	Contract A.46.e	Are Workers required to have Workers' Compensation insurance?	No. Pursuant to Pro Forma Section D.32 coverages are applicable to the contractor and do not apply to the members served under the contract. See item #8 below.
33.	19	Contract A.46.e	Is the Fiscal Employer Agent contractor responsible for obtaining/maintaining a Workers' Compensation policy for Employers?	See response to 32 above
34.	19	Contract A.46.e	If Workers' Compensation is currently being provided, what is the current Workers' compensation rate?	See response to 32 above

35.	19	Contract A.46.e	If Workers Compensation is currently being provided, is it through individual polices per employer or through an umbrella policy?	See response to 32 above
36.	19	Contract A.46.g.3	How and how often are "authorizations for Consumer Direction and self-direction" received?	Authorizations are submitted electronically daily using an agreed upon data interface between the MCO and FEA which can include standard electronic file transfer or FEA web portal technology. For the 1915(c) waiver populations, which currently only includes the SD waiver until CMS approves the use of CD for CAC and SWW members, DIDD submits authorizations to the FEA manually.
37.	19	Contract A.46.g.9	Please provide examples of the" information received from and transmitted to an MCO or DIDD as applicable". How and how often is the information received and transmitted?	Members PCSP or ISP, service authorizations, and any member-specific information. Information will likely be received daily.
38.	26-31	Contract A.74	Would the State consider building a table that provides the report name, date of submission and whether the report is hardcopy, softcopy or transmitted data, and when the report is required for dates of holidays or weekend? This section of the contract does not provide this information consistently.	Please see Exhibit B to Amendment #2
39.	26	Contract A.74.b	Would the State consider extending the submission of the monthly Consumer Direction and Self-Direction Count Report from the 1st of the month to the 3rd or 5th of the following month?	No
40.	36	Contract A.90	What is the standard payment schedule including frequency (i.e., weekly, bi-weekly, semi-monthly)?	Bi-weekly
41.	36	Contract A.90	Are Workers paid to attend the pre-orientation if they are not cleared to provide services?	No, see RFP Attachment 6.6, Pro Forma Contract Section A.39.
42.	36	Contract A.90	How are Workers paid (i.e., check, EFT or debit card) and how many workers are being paid by each method currently?	EFT or paper check; about 14% of workers receive paper checks.
43.	36	Contract A.90.d	Please provide the estimated number of checks that are typically provided outside of the standard payment schedule.	There have been 294 within the past 12 months

44.	37	Contract A.90.d	Do all of the outside standard payment schedule payments need to be made by paper check? If not, please provide the payment types that may be used (i.e., check, EFT or debit card).	No, payments can be paper check or EFT; however, in accordance with A.90.d. the Contractor must implement a process that includes the capability to process payment daily if requested to include a manual process for issuing payroll checks.
45.	38	Contract A.90.u	How many stop payments and payments reissued were required during the most current 12 months?	224
46.	39	Contract A.91	What is the "appropriate frequency"? Who determines the frequency and does the new contractor have any flexibility to determine the appropriate frequency?	The appropriate frequency is at least daily. The frequency is determined by TennCare and the Contractor does not have the ability to change the frequency.
47.	39	Contract A.93	What is the current format required for claims submitted for "Members in Katie Beckett Part B"?	See Pro Forma Section A.91
48.	40	Contract A.96	We assume since this requirement starts with "The Contractor Shall" to mean this information is not required in the Technical Proposal. Please confirm.	This is a requirement of the Contract itself and not a requirement of the Technical Response for evaluation purposes.
49.	44	Contract A.99	Does a Member Advocacy Group current exist? If so, would the State prefer to keep the current members or develop a new Member Advocacy Group?	Yes. The contractor shall develop and maintain their own member advocacy group.
50.	46	Contract A.102.a.7	"…the method in which the check in and check out is made." We assume this refers to mobile, web, telephone or paper. Please confirm. If our assumption is incorrect please provide a definition.	Correct
51.	75	Contract E.26	Does the current contractor have the same requirement to develop and provide a comprehensive Transition Plan?	The current FEA contracts include transition requirements. See Contract Section E.28: https://www.tn.gov/content/dam/tn/tenncare/documents2/PublicPartnerships56969.pdf See Contract Section E.25: https://www.tn.gov/content/dam/tn/tenncare/documents2/MorningSun71808.pdf
52.	Size		Approximately how many Participants are in this program?	See response to question 5
53.	Size		On average how many new enrollments does each program generate monthly?	CHOICES – Avg of 57 new enrollees each month over the last year. KB – Average of 15 ECF – Average of 25 SDW – 2 We are also expecting CD will be available in our CAC and Statewide 1915(c) waiver and we project enrollment to be the following: CAC – 4 Statewide - 45

54.	Size		How many F/EA providers participate in the program?	We currently have two FEAs; however, with this contract we are combining and there will only be one FEA.
55.	Size		What is the average monthly Budget/Authorization amount?	Budget/authorization amounts are member specific and can fluctuate; there are also cost caps for programs. For CD the average participant budget size per year by program is: CHOICES - $18,158 ECF - $15,056 Katie Beckett - $4,406 SDWP - $29,251
56.	Size		What is the average time that a participant remains in the program?	CHOICES – Average 784 days ECF CHOICES – Average 772 days
57.	Scope		Are Budgets/Authorizations dollar-based, unit-based or both?	Both
58.	Scope		Are goods and services reimbursed through the F/EA?	Yes
59.	Scope		What is the length of the authorization for services?	Services are authorized on an annual basis
60.	Scope		What services are covered under this program?	Financial Administration and the following services are available for consumer direction: CHOICES: attendant care, personal care, in-home respite, companion care ECF CHOICES: personal assistance, supportive home care, hourly respite, and community transportation 1915(c) waivers: Day Services which are not facility-based, Individual Transportation Services,Personal Assistance, Respite Services Katie Beckett: Respite, Supportive Home Care, Community Transportation.
61.	Scope		What is the breakdown of participants by grand region of the state (West, Middle and East)?	For CHOICES, ECF CHOICES, KB, and SDWP as of September 2022: East – 1,581 Middle – 1,555 West – 1,068
62.	Implement ation operations		During the period from April 1, 2023 - June 30, 2023, will the awardee be delivering services to participants? Or is that period an implementation period?	No billable services will be required of the awarded contractor during the April 1, 2023 to June 30, 2023. The current contractor will continue to deliver services during this unfunded implementation period.
63.	Implement ation operations		If we wished to subcontract with a support broker that already serves Medicaid programs in the state, does that in itself constitute a conflict of interest per this RFP?	In accordance with RFP Attachment 6.2. – Section A, item ref. A.2, Respondents should disclose any proposed subcontractor that holds a currently effective contract with the State of Tennessee. All such disclosures will be reviewed by the State in determining whether a conflict of interest exists.

64.	Implementation operations		How are authorizations communicated to the F/EA?	See response to Question 36
65.	Implementation operations		How often is the budget revised?	Budgets are revised as needed based on member's service needs
66.	Implementation operations		What occurs if a participant over spends his/her budget?	It is the responsibility of the FEA to have a system in place to track service utilization and remaining hours to ensure that members/representative do not exceed their budget.
67.	Implementation operations		Can the participant switch from one F/EA to another? If so, what is the transfer process? Is the successor F/EA required to run another background on the worker (s)?	Post-procurement, there will only be one FEA for all members opting to consumer direct eligible HCBS.
68.	Financials		Are member enrollment fees expected to be included in the monthly per member fee?	There can be a new member fee outside of PMPM
69.	Financials		Are employee enrollment fees expected to be included in the monthly per member fee?	See response to #68 above.
70.	Financials		Are background check fees expected to be included in the monthly per member fee?	Yes
71.	Financials		What is the average dollar amount of each payroll run?	CHOICES - $862,354 ECF – $261,006 Katie Beckett - $16,184 SDWP $328,459
72.	Financials		Is the awardee required to hold a financial reserve to ensure employee payroll? What is the requirement?	Yes, equivalent to one month payroll and administrative expenses. Please see item #9 below.
73.	Financials		Does the program have any deductible or patient pay or patient share?	Some members are responsible for patient liability but that is not managed by the FEA.
74.	Financials		Is there overtime pay built into the budget? What are the requirements regarding overtime pay?	OT is not built into the budget. If OT is paid, it would come out of the person's budget as time and half.
75.	Other		Are there any Participant Workers that are unionized?	No
76.	Other		What is the current satisfaction rate of members served through the program(s)?	The FEA is responsible for conducting satisfaction surveys; however, we do not have an overall rating at this point available.
77.	Other		At the end of the 3-year contract term, does the state reissue another RFP, or can the term of the existing contract be renewed or extended by another mechanism?	In accordance with RFP Attachment 6.6, Pro Forma Section B.2 – Renewal Options, "This Contract 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 by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of Sixty-Three (63) months." Any renewal option will be executed via an Amendment to the Contract.
78.	Support Brokerage		Would the 3 years of Support Brokerage experience in Medicaid need to be demonstrated by a	

			subcontractor as well as the F/EA respondent? Would a subcontractor's Support Coordination experience in a 1915 (c) waiver suffice for the experience needed (RFP ATTACHMENT 6.2., item A.5.)?	Yes, it would need to be demonstrated by FEA and if subcontractor. Yes, a subcontractor's Support Coordination experience in 1915c would suffice.
79.	Support Brokerage		"Should the definitions in Proforma Contract Attachment "A" also include the role of the Support Coordinator for the 1915 (c) Comprehensive Aggregate Cap and Statewide Waivers?	Definitions have been added to Attachment A.
80.	Support Brokerage		(The definitions include the roles of the "Care Coordinator" for CHOICES, the "DIDD Case Manager" for the 1915 (c) Self-Determination Waiver, the "Nurse Care Coordinator" for Katie Beckett Program Part A, and the "Support Coordinator" for ECF CHOICES, but not the role of the Support Coordinator in other two 1915 (c) waivers.) "	Role of the ISC is very similar to the CM and SC roles.
81.	Support Brokerage		Specifically, can and will the Support Broker Lead position be employed directly or subcontracted by the F/EA respondant to the RFP (Proforma Contract A.7.d.)?	They can be either employed or subcontracted
82.	Technology and Systems		What are the states' expectations for the F/EA related to use of Therap? When would those requirements be active?	These are to be determined and will be further delineated in 2023. At this time, it is not anticipated that the FEA will be expected to use Therap.
83.	Technology and Systems		Can an F/EA choose to use its preferred EVV aggregation technology?	Yes, subject to TennCare approval.
84.	Technology and Systems		Are we able to use 270/271 for eligibility checks?	Yes
85.	Technology and Systems		Is the preferred format for billing 837/835?	See Pro Forma Section A. 91
86.	Current Providers		Who is the current F/EA provider(s)?	See response to Question #1 above
87.	Current Providers		Who is the current Support Broker Provider?	Same as current FEA
88.	Current Providers		What is the current monthly fixed fee per Beneficiary receiving F/EA services per month? For Support Coordination?	See response to question #3 above.
89.	Payroll Requirements		What frequency is required for worker payroll?	See RFP Attachment 6.6, Pro Forma Section A.90.c.
90.	Payroll Requirements		What (if any) are the requirements regarding the pay cycle (i.e., max days between last day worked and pay received)?	In accordance with A.90.c. the Contract would be responsible for developing a payment processing schedule for Workers that must be approved by TennCare.
91.	Payroll Requirements		Do pay stubs need to be mailed to employees or can they be made available on the F/EA's web portal?	Can be made available on the web portal
92.	Payroll Requirements		Is Direct Deposit or debit card the only payment methods? Are paper checks required?	See RFP Attachment 6.6, Po Forma Section A.90.u. "The Contractor shall provide Workers with the option to receive payment via either mailed check or Electronic Funds Transfer;"

93.	Payroll Requirements		What days do the pay periods start and end (i.e. Sunday through Saturday or Saturday to Friday etc.)	See response to Question #90 above.
94.	Payroll Requirements		Does the state provide funding for payroll to the F/EA prior to the payment to the Participants' workers (i.e. Fund payroll in advance) or is the F/EA expected to pay the workers and then bill the state?	See RFP Attachment 6.6, Pro Forma Section C.5.
95.	Payroll Requirements		How do Participants' Workers select how they want to be paid (i.e. weekly, bi weekly, monthly)?	Contractor develops pay schedule and is approved by TennCare.
96.	Payroll Requirements		Can you provide a breakdown of the number of employees on the weekly pay schedule, the monthly pay schedule and the biweekly pay schedule?	Employees are paid on a bi-weekly schedule. See response to #5 above.
97.	Payroll Requirements		What modalities are expected for recording worked hours for Participant's Workers (e.h., paper timesheets, online timesheets, EVV)?	The Contractor is responsible for having a Timekeeping System in place per contract.
98.	Payroll Requirements		What is the expected timeframe for the F/EA to contact the Participants' Workers / Employers to correct timesheets?	See RFP Attachment 6.6, Pro Forma Sections A.92 and A.93
99.	Payroll Requirements		Is Workers' Compensation Insurance required for employees? If not, what % of workers opt for workers comp?	See response to question #32
100.	Payroll Requirements		Is workers compensation coverage required for employees of program beneficiaries?	See response to question #32
101.	Payroll Requirements		Are there other requirements for the provision of workers compensation insurance?	See response to question #32
102.	Payroll Requirements		Are there any unusual payroll-related taxes (other than fica, futa, suta) that need to be managed in the payroll process?	No. See RFP Attachment 6.6, Pro Forma Sections A.90.n through A.90.v.
103.	Customer Service		What is the average number of customer service calls received per day, per week and per month?	Averages below are for all programs combined for April – June 2022: 221/day 1540/week 6675/month
104.	Customer Service		What percentage of employers are expected to submit time online?	There is not a set percentage
105.	Customer Service		What is the current average talk time for call center agents?	For Quarter 2 in 2022 (April – June), the average time on call was 9 minutes.
106.	Onboarding		What role is the F/EA expected to play in the creation of the Participants' Person Centered Support Plan (PCSP)?	The FEA assists the consumer directed member in the creation of the back-up plan, which is integrated into the member's PCSP.
107.	Onboarding		What background checks are required for Participants' workers during enrollment? Are any other background checks required?	HHS-OIG, SAM, Social Security Death Master File, and other exclusion and/or other professional board databases, as applicable. (Pro Forma Section A.30.b)
108.	Onboarding		Are the costs for background checks part of the participant's budget or included in the PMPM (per member per month) F/EA fee?	Part of the FEA fee
109.	Onboarding		How often background checks run on a worker (i.e. one time only, every two years, every four years)?	Background checks must be completed prior to the worker having direct contact with a member

110.	Onboarding		Is there a specific background check provider that is the states wants F/EAs to use? Are there specific exclusion lists (e.g., oig)?	No. See response to Question #107
111.	Onboarding		Can an employer (participant) opt to not perform a criminal background check on a prospective employee?	See Pro Forma section A.30.b. "... A Member/Representative cannot waive a background check for a potential Worker."
112.	Onboarding		Is the employer (participant) allowed hire an employee who's background check shows issues (e.g., convictions)? What are the requirements regarding this?	Yes. See RFP Attachment 6.6, Pro Forma Sections A.31. and A.32
113.	Onboarding		Are there specific requirements for data transfer between F/EAs when a participant transitions from one to another? What are they?	Post-procurement, there will only be one FEA for all members opting to consumer direct eligible HCBS so there would be no transitions.
114.	Vendor Management		What is the timeframe for reimbursing for pass-through claims including the claims related to the hourly services provided by employees of the participant (Medicaid recipient receiving the self-directed services)?	The FEA will receive payment for claims submitted by the FEA within 14 calendars days of submitted claims.
115.	Vendor Management		Do we need to run a criminal background check on individual vendors?	Yes, in accordance with A.30.b of the contract. See RFP Attachment 6.6, Pro Forma Section A.30.b.
116.	Training		What employee/caregiver trainings are required?	This is outlined in A.28 of the contract. See RFP Attachment 6.6, Pro Forma Section A.28
117.	Training		What support coordination and/or case management trainings are required?	See response to question #119 below
118.	Training		Are there trainings provided by the state (or MCO) that the F/EA is responsible for ensuring are completed?	This is outlined in A.28 of the contract. See RFP Attachment 6.6, Pro Forma Section A.28
119.	Training		What Support Broker trainings are required?	See A.87. which includes the required training that the FEA must provide to its staff.
120.	General		What is the average budget size, as well as the minimum and maximum budget sizes?	See response to Question 55 for average budget size. There is no minimum budget size. The maximum is determined by program eligibility and will vary by member based on other needs. Below are the 2022 individual cost caps/expenditure cap by program which would be higher than the maximum budget size for consumer directed services: CHOICES Group 2: $82,250 CHOICES Group 3: $18,000 CHOICES Group 4: $18,000 CHOICES Group 5: $36,000 CHOICES Group 6: $189,375 Self-Determination waiver: $36,000 Statewide Waiver: $189,375 Comp Aggregate Cap waiver: none
121.	General		What is the timeframe for reimbursing for pass-through claims including the claims related to the hourly services provided by Workers of the Member (Medicaid recipient receiving the self-directed services)?	See response to question #114
122.	General		Can you please confirm the current number of Members in each waiver program and how many	See response to question #5 for current number of members. Based on historic

			Members you anticipate over the life of this contract?	utilization and trends, we anticipate a the following % change by 2026: CHOICES: 9% increase ECF CHOICES: 32% increase (dependent upon enrollment) SDWP: -3% decrease
123.	A.47		Does the State require face-to-face enrollment visits or are virtual and/or phone enrollments allowed?	See RFP Attachment 6.6, Pro Forma Section A.47.
124.	General		What are the background check requirements for Workers? Are the costs for background checks part of the Member's budget or included in the PMPM (per member per month) FMS fee?	See response to Question #107 and #108 above
125.	General		If there are background check requirements, what is the fee? Also, is fingerprinting required? Lastly, what is the average time it takes for results to be determined?	Fees and result times associated with background check requirements are based on the company used. Fingerprinting is not required if the background check is from a licensed private investigation company.
126	General		Is workers' compensation insurance required?	See response to Question #32.
127.	General		Are there any specific Worker trainings required?	See response to Question #118.
128.	General		What is the current PMPM FMS fee?	See response to Question #3
129.	General		What is the average number of Workers per Member?	2-3
130.	C.5		Does the State allow for invoicing for claims within the same month of services?	Please see RFP Attachment 6.6, Pro Forma Section C.5
131.	C.5		What is the frequency of submitting claims allowed by the State?	Please see RFP Attachment 6.6, Pro Forma Section C.5.
132.	C.5		Does the contractor have to wait a required amount of time after the service is completed to submit for reimbursement of claims? If so, what is the amount of time?	Please see RFP Attachment 6.6, Pro Forma Section C.5.
133.	General		What is the timeframe for reimbursing for provider-related claims, including the financial management PMPM claim?	For provider related claims, see response to Question 114. For administrative reimbursement, payments are 30 days ARO
134.	General		What is the length of the authorization for services?	See response to Question #59
135.	General		Does the State allow providers to draw down funds related to authorized services?	Providers (Workers) are reimbursed for services provided that have been authorized.
136.	General		What is the current employer payroll tax?	Employer payroll taxes are determined by the IRS. For more information, please see the most current IRS Publication 15 (Circular E).

				https://www.irs.gov/pub/irs-pdf/p15.pdf
137.	A.8	Page 18	For question A.8 in the Technical Response and Evaluation Guide, what kind of proof are you looking for regarding an EVV-compliant timekeeping system?	Please see revised Mandatory Requirement Item A.8 below. Please see item #5 below.
138.	General		Can you please confirm the 50:1 ratio for Members to Support Brokers is for all programs? If the ratio is for all programs, this will significantly impact pricing.	Yes
139.	General		Are semi-annual face-to-face visits required for all Members or just Members of certain programs?	All members
140.	General		Can you please confirm that we are able to email the full proposal to the contract monitor rather than printing and mailing one copy and six flash drives of the Technical and one printed copy and one flash drive of the Cost proposal?	Yes, email proposals can be submitted to the Solicitation Coordinator. See revised RFP Section 3.2, Response Delivery below. Please see item #4 below.
141.	General		Can you please confirm that electronic signatures are acceptable as opposed to wet signatures?	Yes, electronic dated and time stamped signatures are acceptable.
142.	General		Will the contractor be required to aggregate EVV data with a national aggregator? If so, what national aggregator is the State currently using?	The state is not utilizing a "national aggregator."
143.	General		Is IVR required or are other EVV-compliant solutions acceptable?	Other solutions acceptable (i.e. gps tablet and mobile app/personal device)
144.	General		Regarding references, if our company has never closed a contract of similar size and scope, are three references from completed contracts still required as per Attachment 6.4 of the RFP? If so, can we utilize references from contracts of similar size and scope that have been renewed to satisfy this requirement?	References are not required per question #26, but a respondent may utilize references as described in this question.
145.	B.2		Section B.2 states that the Contract may be renewed for up to two renewal options at the State's sole option. Will the State be updating Contractor's rates based on factors such as inflation and cost of doing business?	No, RFP Attachment 6.3, Cost Proposal & Scoring Guide requires that the respondent provide rates for the renewal option years that are anticipated for the option years beginning July 1, 2026 through June 30, 2028.
146.	C.1		Section C.1., what will be the Maximum Liability for this contract? If an exact amount is not able to be specified, does the State foresee this being less than the amount owed during the uncompensated transition period?	The contracts Maximum Liability is determined by the respondent's proposed cost of services in RFP Attachment 6.3, Cost Proposal & Scoring Guide
147.	C.3.b		Section C.3.b. states that 4/1/23 through 6/30/23 is an uncompensated transition period. a. Does this also apply to the claims processed on behalf of Members and their Workers? b. Is the expectation that the Contractor float these costs for this period? If so, will there be additional compensation in the form of interest for this?	The contractor is not expected to perform billable services during this period. Billable services are to begin July 1, 2023. No Compensation in the form of interest will be applied during this uncompensated period.

148.	A.94		Section A.94 and Section C, what will be the regular payment timeline for when Contractor will be paid by the State for claims and compensation?	See response to question #133
149.	A.93		Section A.93 is the 120 days the claims submission deadline generally? For example, if the Members/Workers turn in timesheets late can they be reimbursed up to 120 days of submission?	120 days from date of service, not date of submission.
150.	D.5		Section D.5, will the State allow for Contractor to also have Termination for Convenience rights?	No.
151.	Section 3.2	Page 7	Section 1.4.5 indicates that digital submissions are encouraged but Section 3.2 Response Delivery instructions are specific to mail/parcel delivery. Can the State please provide instructions for email delivery, including guidance on file size attachments, method for separating cost and technical responses, and requirements, if any, around copies of the original electronic submission?	Please see response question #140 and item #4 below.
152.	Section 4.8	Page 11	May vendors submit redacted versions of their technical responses to be used for public disclosure to protect confidential and proprietary information?	The State does not accept redacted proposals.
153.	Section 5.2.1.5	Page 14	This section refers to meeting "responsive and responsible thresholds." Can the State provide more information regarding what standards are used to determine these thresholds?	Sections A, B and C establish the thresholds for a responsive and responsible submission, The Respondent must meet the requirements included in Section A, B, and C in addition to those of the RFP.
154.	Attachment 6.2 Section A	Page 7	Can the State confirm that the first six rows of Attachment 6.2, Section A are for State purposes only and do not require a vendor response?	Correct, although it is the respondent's responsibility to adhere to the requirements for each of these items included in Section A to ensure the submission is responsive.
155.	Attachment 6.2 Item A.5	Page 18	Does the State have a specific form it wants vendors to use in submitting "proof" of at least three years of experience providing both FEA and Supports Broker services in Medicaid? (for example, attestation, client contact information, etc.?) Can the State also confirm that this experience threshold must be met by the prime contractor and not through a subcontractor or through the professional experience of an individual employee?	Please provide a narrative of prior experience that includes documentation of providing both FEA and Support Broker Services, this may include attestations, client information, references to current or previous contracts held by the respondent. Subcontractor experience is applicable to meeting the requirement for A.5.
156.	Attachment 6.2 Item A.6	Page 18	Does the State have a specific form it wants vendors to use in submitting "proof" of at least three years of experience supporting Consumer Direction in managed care, including working with multiple managed care organizations (for example, attestation, managed care client contact information, etc.?) Can the State also confirm that this requirement must be met by the prime (not by a subcontractor or individual employee) and that "supporting consumer direction" includes the full range of FEA business processes and not just a single or subset of tasks such as EVV only?	Please provide a narrative of prior experience that includes documentation of providing Consumer Direction in managed care, this may include attestations, client information, references to current or previous contracts held by the respondent. Subcontractor experience is applicable to meeting the requirement for A.6.
157.	Attachment 6.2 Item A.8	Page 18	Does the State have any requirements around the type of "proof" it wants vendors to submit to verify "a system of documenting time comports fully with EVV	Please see revised Mandatory Requirement Item A.8 below. Please see item #5 below.

			requirements of the 21st Century Cures Act and which aggregates electronic visits and claims data?"	
158.	Attachment 6.2, Item A.8	Page 18	Can you clarify that "aggregate" in this section does not refer to providing statewide aggregation for all providers subject to EVV requirements? We interpret this requirement to mean aggregate EVV information only for those providers employed by the self-directing participants enrolled in the programs that are included in this RFP, for purposes of payroll administration and reporting needs.	Correct. This requirement is specific to EVV information for consumer directed individuals
159.	Attachment 6.2, Item B.15	Page 20	Can the State confirm that, although documentation of commitment to diversity is positively scored, this RFP does not include a specific target or minimum commitment of percentage participation for business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises?	No scoring criteria is applied to diversity participation for evaluation and there is no target minimum for the percentage of participation.
160.	Attachment 6.2, Item B.18	Page 22	Can the State define the term "not renewed" as it is used here? Does this exclusively mean situations in which a client did not exercise an option year available under a contract?	Correct.
161.	A.45	Page 54	Does the 50:1 Support Broker ratio apply to all programs or only to the Self-Determination Waiver Program?	See response to question #138
162.	A.47	Page 55	Do semi-annual face to face visits, one of which must be at the Member's place of residence, apply to all programs or only to the Self-Determination Waiver Program?	All programs
163.	A.10	Page 3	"The Contractor shall, upon request or approval from TennCare or an MCO for Members, and pon request or approval from DIDD for Members, coordinate with TennCare, the MCO, or DIDD, as applicable, to conduct outreach activities for Members, as specified herein." Question: Are the current outreach activities for identified Members currently listed regionally? How many identified members are listed per region?	Not all outreach activities are done regionally.
164.	A.5 and A.6	Page 18	"A.5 Provide proof of at least three (3) years of experience providing both FEA and Supports Broker services in Medicaid." "A.6 Provide proof of at least three (3) years of experience supporting Consumer Direction in managed care, including work with multiple managed care organizations." Question: Will the state please define proof.	See response to question #155 and #156
165.	A.30	Page13	"Complete a background check, which includes a criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company, verification that the person's name does not appear on the State abuse registry, verification that the person's name does not appear on the State and national sexual offender registries, and verification that the	The background check cost is dependent upon the company used to complete it. In accordance with C.3. the set-up fee includes the cost of the background check.

			person has not been excluded from participation in Medicare, Medicaid, SCHIP, or any federal health care programs (as defined in Section 1128B(f) of the Social Security Act as determined by appearance on the Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the General Services Administration (GSA) System for Award Management (SAM), the Social Security Death Master File, and other exclusion and/or other professional board databases, as applicable.)." Question: What is the cost of the criminal background check? Who pays for the criminal background check for the employees of the self-directed participant? Can the Contractor deduct the cost of the criminal background check from the participant's budget?	No, the cost cannot be deducted from the participants budget
166.	5.3.3	Page 15	"The State will issue a Notice of Intent to Award identifying the apparent best-evaluated response and make the RFP files available for public inspection at the time and date specified in the RFP Section 2, Schedule of Events." Question: Where will the notice of intent to award be published?	The Notice of Intent to Award will be distributed via email communication to all respondents that submitted a qualifying proposal to RFP 31865-00633.
167.	A.46.b	Page 19	"Monitor assignment of Workers by the Member/Representative, including the Contractor's entry of such assignment into the Timekeeping System, to ensure service utilization in accordance with the units or monthly or annual budget, as applicable, of Consumer-Directed or Self-Directed services specified in the PCSP, as applicable, and in the service authorization, and notify the Member's Care Coordinator, Nurse Care Manager, or Support Coordinator, or Case Manager, as applicable, when a Member's needs have changed;" Question: If a participant does not spend all of their budget in a single month, can they "roll over" funds to a subsequent month? If so, how long/how much may a participant roll over funds until such funds are considered non-usable or are to be forfeited?	Services should be provided in accordance with the service authorizations and limits.
168.	A.94 and A.95	Page 38	"Claiming and Payment for Consumer-Directed and Self-Directed Services" Question: Is the F/EA required to disburse the payroll for thirty days before receiving the corresponding funds from Medicaid?	See Response to Question 114
169.	D.32.b	Page 58	"Workers' Compensation and Employer Liability Insurance" Question: Is the cost of workers' compensation deducted from the member's budget?	See response to Question #32.
170.	A.87.d (footer)		"As appropriate, train PPL staff on how to use the EVV solution and requirements for Electronic Visit Verification Compliance and monitoring." Question: If a new contractor is awarded this bid will PPL's EVV solution be fully replaced, or will the new contractor need to aggregate claims into PPL's Time4Care EVV application?	The reference to PPL is in error. PPL will be removed from this section. If a new contractor is awarded this bid, the contractor will be responsible for implementing their own EVV system that is fully compliant with the 21st Century Cures Act.

				See item #7 below.
171.	General (Budget)		What is the anticipated size of an member's ISP budget?	See response to Question #55
172.	General (Payment)		After claims are submitted to the MCO, how quickly is the contractor paid?	See response to Question #168
173.	General (Attachment 6.2, Section B)		Section B does not describe the evaluation criteria. Should it contain a Pass/Fail or Evaluation Factor column?	Section B receives a holistic score of 30 points. Please reference the header guidance included in FFP Attachment 6.2, Section B as follows: **SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE.** The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. Proposal Evaluation Team members will independently evaluate and assign one score for all responses to Section B—General Qualifications & Experience Items.
174.	General (EVV)		Who is the State's Current EVV vendor?	See response to Question #200 below.
175.	General (EVV)		Does the current Statewide EVV vendor perform aggregation services?	See response to question #174
176.	General (Pricing)		What is the current vendor's total fee for Financial Administration, Supports Brokerage, and new Consumer Direction Participant and Worker setup fees?	Financial Administration - $80 Per Participant Per Month (PMPM), Support Brokerage - $105 PMPM, New Consumer Direction - $95 Per Participant
177.	General		How many support brokers currently manage the programs identified in this RFP?	45
178.	General		Can you provide the number of Support Brokers by city name currently providing these services (i.e. Nashville - 15, Johnson City - 2, etc.)?	Antioch 2 Arlington 1 Atoka 1 Bluff City 1 Camden 1 Chattanooga 1 Clarksville 3 Cleveland 1 Collierville 2 Cookeville 1 Cordova 1 Crossville 1 Georgetown 1 Greeneville 2 Hendersonville 1

				Humboldt 1 Jacksboro 1 Jackson 1 Johnson City 2 Kingsport 1 Knoxville 3 Lavergne 1 Memphis 4 Mt Juliet 1 Murfreesboro 2 Nashville 1 Old Hickory 1 Olive Branch 1 Soddy Daisy 1 Spring Hill 1 OPEN 3
179.	General		Is there a maximum number of miles from the self-directed employer a support broker can be physically located?	No
180.	General		How many current participants in: CHOICES? ECF CHOICES? Section 1915(c) HCBS Waiver Programs? Katie Beckett Programs?	Please see response to question #5
181.	General		What is the rate of growth expected per year for each program?	See response on question #21
182.	General		What is the daily average number of inbound calls that need to be answered within 30 seconds?	There is not a required number of calls that must be answered within 30 seconds; however, the Contractor is required to report on the number of calls answered within 30 seconds.
183.	General		What is the difference between saving an Excel Spreadsheet as a PDF format or a PDF/XLS format?	The cost proposal may be submitted in either PDF or XLS format.
184.	General		For the Technical Response Digital Copy, should it be one PDF, or can it be broken up into labeled PDF's (i.e. Technical Response A, Technical Response B, etc.)?	Please see response question #140 and item #4 below.

185.	General		What is the difference between workers and employees?	Workers are direct care staff for members. Employees are managers, administrative staff, supports brokers, etc. employed by the FEA
186.	General		What is the difference between Consumer Direction and Self-Direction programs?	Consumer direction is the term used for Employment and Community First CHOICES and CHOICES programs, while self-direction has been used for the 1915(c) Self-Determination waiver. The terms have the same meaning.
187.	General		At the Pre-Response conference, it was mentioned that an electronic submission could be provided. This option is not referenced in the written RFP. Will an electronic submission be accepted as a response to this RFP?	Please see response question #140 and item #4 below.
188.			Will schedules be required for the direct support professionals?	Yes
189.	General		One of the contract requirements states: "Develop and implement a process for processing payment to workers outside of the standard payment schedule, as requested by TennCare, including the capability to process payment daily if requested….) Is there an expectation that payroll would routinely be processed daily, or only in a specific circumstance?	This would not be a routine request, but would need to be possible through the Contractor's system functionality for specific situations.
190.	General		Is payroll currently processed via EVV data only? If not, what percentage of payroll is currently processed via paper timesheet submission?	No
191.	General		What is TennCare's expected timeframe for correcting errors on timesheets or missing timesheets?	See RFP Attachment 6.6, Pro Forma Section A.92 and A.93
192.	General		What is the process for worker's obtaining Medicaid ID's?	The FEA uploads a file to TennCare to request a Medicaid ID.
193.	A.39		Are there existing worker trainings provided by the state or will the FI be responsible for creating all required trainings for workers?	In accordance with A.39. the FEA's Support Broker is responsible for providing for or arranging for initial and ongoing training of all workers. CPR and first aid training may not be provided directly by the FEA; however, the FEA is responsible for providing access to training.
194.	Definitions		What is the definition of each of the following:	Definitions have been added to Attachment A. See Item #6 below.

			employer authority budget authority modified budget authority?	
195.	A.90.c		Does the FI implement the payment schedule? Can it be weekly, biweekly, or whatever frequency the FI determines?	See RFP Attachment 6.6, Pro Forma Section A.90.c.
196.	General		What is the purpose of obtaining a worker's Medicaid ID? Is this used for billing instead of the FI's provider ID?	This is necessary to ensure each worker is appropriately registered with TennCare and ensures TennCare and the MCOs are able to prevent and foreclose potential fraud, waste, and abuse by specific workers.
197.			Is payroll billed at the Medicaid Rate or actual?	The State has rates that are specific to Consumer Direction which are all Medicaid rates. There is a Worker Rate and a Billable Rate.
198.	General		Is the expectation that the contracted FI provide an aggregator? Or will the FI send aggregated information to the State of Tennessee's aggregator?	The State of Tennessee does not have an aggregator. See question # 199 below.
199.	General		Section A.8. of the RFP states: "Provide proof of a system of documenting time that comports fully with EVV requirements of the 21st Century Cures Act, and which aggregates electronic visits and claims data." Can you clarify the requirements and responsibilities the contracted FI will assume relating to "aggregates electronic visits and claims data"?	The FEA is required to have a fully functional and compliant independent EVV system.
200.	General		Has the state received CMS certification for their EVV system?	The state does not have an independent EVV system. Each MCO has EVV systems that have been deemed compliant with the 21st Century Cures Act for PCS.
201.	A.8	18	Can the state please provide a workflow of the aggregation? What exact data elements will require aggregation?	There is no state aggregator. The vendor is expected to aggregate their data and provide to the MCOs. Elements related to EVV requirements of the 21st Century Cures Act for PCS services.
202.	A.8	18	Where is the data being originated, and where is it being aggregated to?	The data is originating in the FEA EVV system and being aggregated internally by the FEA and provided to the MCOs.
203.	A.8	18	Has the State determined the total number or an estimate of aggregation beginning and end points?	No. Question related to "beginning and end points" unclear.
204.	A.8	18	Will APIs be available for aggregation? If not, what is the proposed data transfer method? How often will the data need to be aggregated?	See response to question #201 above.
205.	A.8	18	Will the state require any aggregation from third party EVV vendors?	No, the FEA is the vendor.

206.	A.8	18	Does the state currently have any contracted EVV vendors and if so, who are they?	See response to question # 200 above.
207.	A.8	18	Does the state have a process for vetting third party EVV vendors?	Not specific to EVV vendors but there are requirements subcontractor approval.
208.	Contract		Is the proforma contract a starting point for negotiations or will that not be revised in any way?	In accordance with RFP Section 5.3.5 the State may, at its sole discretion, entertain limited terms and conditions or pricing negotiations prior to Contract signing and, as a result, revise the *pro forma* contract terms and conditions or performance requirements in the State's best interests, PROVIDED THAT such revision of terms and conditions or performance requirements shall NOT materially affect the basis of response evaluations or negatively impact the competitive nature of the RFP and contractor selection process.
209.	Contract A.5	5	How many MCO's currently are receiving Financial Administration and Supports Brokerage services? Does the State project this number to increase, remain, or be reduce in the new contract?	Three. No expectation for number of MCOs to increase or decrease in the future.
210.	Contract A.20.e.i	9	How does the FMS verify a workers' relationship status? Will the FMS be expected to do more than ask the parties if there is a relationship and maintain documentation of their response?	Fraud/Attestation form is signed by the worker and member.
211.	Contract A.20.e.ii	9	We assume the State will provide the current workers' addresses for the past five (5) years. Please confirm. If not, how will the new contract receive the address history?	Current workers addresses for past five years will be reflected in transition information from the current FEA. For new workers, the worker inputs their addresses for the last five years in the initial worker paperwork.
212.	Contract A.20.e.ii	9	How does the FMS verify a worker's address? What documentation is required? Will this process continue in the new contract?	The worker attests that the addresses listed are correct with the attestation form clarifying that incorrect information can constitute fraud.
213.	Contract A.46.e	19	"…Monitor services delivered in a back-up capacity." Are backup services issued a distinct service code? If not, how is the FI notified of the use of a backup service?	In accordance with A.90.b of the Pro Forma the Contractor is responsible for establishing the process necessary to track and manage functions including services delivered in a back-up capacity.
214.	Contract A.89.d	36	How frequently is the disaster recovery plan required to be submitted for review and sign-off?	Once, unless changes are made.
215.	Contract A.90.b	36	Will payment/reimbursement or any portion of payment/reimbursement be contingent upon claims being EVV compliant?	Yes pursuant to the requirements of the 21st Century Cures Act.
216.	General		What is the current number of Participants receiving services per waiver/program?	See response to question #5
218.	General		What is the total number of Participants receiving Financial Administration services?	3970
219.	General		What was the total number of Participant months for Financial Administrative services in 2021?	46,865

220.	General		What is the total number of Participants receiving Supports Brokerage services?	3970
221.	General		What was the total number of Participant months for Supports Brokerage services in 2021?	See response to Question 219
222.	General		What is the current number of Consumer Directed Workers per program?	See response to question #5 above.
223.	General		What is the current average Participant budget size by program?	See response to Question 55
224.	General		What is the term of an authorization?	Annually
225.	General		Do authorization terms vary by program?	Services are authorized on an annual basis.
226.	General		What are the current set-up fees for new Participants and Workers?	New participant = $95 New worker = $125
227.	General		What are the current PMPMs?	See response to question #128 above.
228.	A.30.b	48	What are the current fees for each of the required Tennessee-specific background and registry checks? (i.e state criminal background check, state abuse registry, and state sexual offender registry)	Unknown – This is dependent upon the company utilized to complete the background check.
229.	A.30.b	38	Who pays for background checks?	See response to Question #165
230.	A.40	51	The Pro Forma Contract states that the Contractor shall collect documentation that Workers have successfully completed CPR and First Aid Certification. Who pays for the Worker's CPR and First Aid Certifications?	The worker
231.	A.40	51	Does the current vendor direct Worker's to specific CPR/First Aid Certification vendors?	Workers can utilize vendor of their choosing. Current FEA does offer a resource page with certified vendors if a worker needs assistance in finding one.
232.	A.45	54	The contract states that Support Broker caseloads for Members cannot exceed a 50:1 ratio. Is this ratio a requirement for all Members receiving Support Brokerage services across all programs, or is this a requirement only for Members receiving Support Broker services through a specific program?	All programs
233.	A.90	71	What is the current average payroll per pay period by program?	CHOICES - $862,354 ECF – $261,006 Katie Beckett - $16,184 SDWP $328,459
234.	A.90.u	71	How many Workers are currently receiving paper checks in the US mail?	680
235.	C.5		Will there be an electronic option for submitting invoices to TennCare?	Invoices may be submitted via email.
236.	C.5		Could the state provide a sample invoice as referenced in section C.5?	Please see Exhibit A to Amendment #2

237.	C.5		How long does it take the State to send payment to the contractor once the State has received the claim?	See response to Question 133.
238.	C.5		How long does it take for MCOs to pay after they have received claims?	Payments for administrative functions are made from the State which is what is referenced in C.5. See response to question 133. The MCO will only reimburse for provider claims. For reimbursement related to provider claims see response to Question 114.
239.	Attachment B Item 5		Regarding the $250 damages assessed if a Participant receives unapproved material, is the $250 fine assessed per member who receives it? Or is the assessment per piece of educational material regardless of the number of persons to whom the document was disseminated?	Per document
240.	General		What is the current size of the population receiving FMS services by Waiver Program?	See response to question #5
241.	General		What is the current number of participants receiving Supports Brokerage services by Waiver Program?	See response to Question 5 above
242.	General		What is the anticipated annual growth of the program?	See response to question #21
243.	General		What is the number of new participants that have been set up in the past 12 months?	ECF – 297 KB – 174 SDWP – 21 CHOICES - 680
244.	General		What is the number of direct care workers that have been set up in the past 12 months?	ECF – 1,191 SDWP – 81 KB – 54 CHOICES – 1,612
245.	General		Are authorizations based on units or dollars?	Both
246.	General		What time period are authorizations based on (i.e. Bi-weekly, Monthly, Annually etc.)?	Annually
247.	General		Is Overtime allowed? If yes, in which programs?	ECF – yes. SDWP – No See Pro Forma A.48
248.	A.20 and A.77	Page 8 and Page 32	How many MCOs will be sending Electronic Authorization and Eligibility files to the FMS? Will DIDD send an Electronic Authorization and Eligibility files as well? Are the Electronic Authorization and Eligibility files universal across all MCOs and DIDD if applicable? How are they sent?	There are 3 MCOs and all will send electronic authorizations and eligibility files to the FEA. For DIDD for the SD waiver, authorizations are manual the current FEA bills manually for individuals enrolled in that waiver. For KB Part B authorizations are sent electronically. The files are universal.
249.	A.28	Page 11	What is the frequency for the required ongoing training?	The ongoing training is required upon request of member/representative, or if a Care Coordinator, Support Coordinator,

				Nurse Care Manager or DIDD Case Manager, determines that additional training is warranted.
250.	A.90.i	Page 37	How does the current FMS ensure services are being provided? Is there a tool or reporting mechanism employed?	EVV
251.	Attachment B – Liquidated Damages		What is the amount of liquidated damages that have been assessed in the prior contract term broken down by year?	One damage assessment in the amount of $1,000.00 occurred in 2021. No other damage assessments have been applied.

3. Delete RFP Attachment 6.3. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

RFP ATTACHMENT 6.3.

COST PROPOSAL & SCORING GUIDE

NOTICE: THIS COST PROPOSAL MUST BE COMPLETED EXACTLY AS REQUIRED

COST PROPOSAL SCHEDULE— The Cost Proposal, detailed below, shall indicate the proposed price for goods or services defined in the Scope of Services of the RFP Attachment 6.6., *Pro Forma* Contract and for the entire contract period. The Cost Proposal shall remain valid for at least one hundred twenty (120) days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract resulting from this RFP. All monetary amounts shall be in U.S. currency and limited to two (2) places to the right of the decimal point.

NOTICE: The Evaluation Factor associated with each cost item is for evaluation purposes only. The evaluation factors do NOT and should NOT be construed as any type of volume guarantee or minimum purchase quantity. The evaluation factors shall NOT create rights, interests, or claims of entitlement in the Respondent.

Notwithstanding the cost items herein, pursuant to the second paragraph of the *Pro Forma* Contract section C.1. (refer to RFP Attachment 6.6.), "The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract."

This Cost Proposal must be signed, in the space below, by an individual empowered to bind the Respondent to the provisions of this RFP and any contract awarded pursuant to it. If said individual is not the *President* or *Chief Executive Officer*, this document must attach evidence showing the individual's authority to legally bind the Respondent.

RESPONDENT SIGNATURE:	
PRINTED NAME & TITLE:	
DATE:	

RESPONDENT LEGAL ENTITY NAME:			
Cost Item Description	**Proposed Cost**	**State Use Only**	
		Evaluation Factor	**Evaluation Cost** (cost x factor)
July 1, 2023 – June 30, 2026			
Financial Administration	**$_____ Per Member/Per Month**	207,000	
Supports Brokerage	**$_____Per Member/Per Month**	207,000	
Set-Up for New Consumer Direction Participant	**$_____/Per Month**	207,000	
Set-Up for New Consumer Directed Worker	**$_____/Per Worker**	2,325	
July 1, 2026 to June 30, 2028			
Financial Administration	**$_____Per Member/Per Month**	138,000	
Supports Brokerage	**$_____ Per Member/Per Month**	138,000	
Set-Up for New Consumer Direction Participant	**$_____/Per Month**	138,000	
Set-Up for New Consumer Directed Worker	**$_____/Per Worker**	1550	
EVALUATION COST AMOUNT (sum of evaluation costs above): The Solicitation Coordinator will use this sum and the formula below to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.			
lowest evaluation cost amount from all proposals / **evaluation cost amount being evaluated**	**x 30 (maximum section score)**	**= SCORE:**	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

4. Delete RFP Section 3.2 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

3.2. **Response Delivery**

3.2.1. A Respondent must ensure that both the original Technical Response and Cost Proposal documents meet all form and content requirements, including all required signatures, as detailed within this RFP, as may be amended.

3.2.2. A Respondent must submit original Technical Response and Cost Proposal documents and copies as specified below.

3.2.1.1. Digital Media Submission

3.2.2.1.1 Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, standard CD-R recordable disc or USB flash drive and should be clearly identified as the:

"RFP #31865-00633 TECHNICAL RESPONSE ORIGINAL"

and six (6) digital copies of the Technical Response each in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, standard CD-R recordable disc or USB flash drive clearly labeled:

"RFP #31865-00633 TECHNICAL RESPONSE COPY"

The sealed customer references should be delivered by each reference in accordance with RFP Attachment 6.4.

3.2.2.1.2 Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "PDF" or "XLS" format properly recorded on a separate, otherwise blank, standard CD-R recordable disc or USB flash drive clearly labeled:

"RFP #31865-00633 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.2.2. E-Mail Submission

3.2.2.2.1. Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should both be clearly identified as follows:

"RFP # 31865-00633 TECHNICAL RESPONSE"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4.

3.2.2.2.2. Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "PDF" or "XLS" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should both be clearly identified as follows:

"RFP # 31865-00633 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.3. For e-mail submissions, the Technical Response and Cost Proposal documents must be dispatched to the Solicitation Coordinator in separate e-mail messages. For digital media submissions, a Respondent must separate, seal, package, and label the documents and copies for delivery as follows:

3.2.3.1. The Technical Response and copies must be placed in a sealed package that is clearly labeled: "DO NOT OPEN… RFP # 31865-00633 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.2. The Cost Proposal must be placed in a separate, sealed package that is clearly labeled: "DO NOT OPEN… RFP # 31865-00633 COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.3. The separately, sealed Technical Response and Cost Proposal components may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled: "RFP # 31865-00633 SEALED TECHNICAL RESPONSE & SEALED COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.4. Any Respondent wishing to submit a Response in a format other than digital may do so by contacting the Solicitation Coordinator.

3.2.4. A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

Donovan Morgan, Assistant Director of Contracts
Department of Finance and Administration
Division of TennCare
310 Great Circle Road
Nashville, TN 37243
(615) 741-0041

5. Delete RFP Section 6.2, Section A, Item Reference A.8 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

	A.8.	Provide written attestation that the Respondent has a system of documenting time that comports fully with EVV requirements of the 21st Century Cures Act, and which aggregates electronic visits and claims data and is capable of the following: The information system to track electronic visit verification must be capable of electronically verifying, with respect to visits conducted as a part of home health care services, the following: a. The type of service performed b. The individual receiving the service c. The date of the service d. The location of service delivery e. The individual providing the service f. The time the service begins and ends There must be the capability of reconciling the authorization/claim data with the EVV visit data in the system to corroborate the	

		accuracy of the EVV visit data elements above (e.g. type of service performed; individual receiving the service; date of service; individual providing the service)	

6. **Delete Pro Forma Attachment A in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

ATTACHMENT A

DEFINITIONS

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 C.F.R. 455.2).

Adult Protective Services (APS) – An office within the Tennessee Department of Human Services that investigates reports of abuse, neglect (including self-neglect) or financial exploitation of vulnerable adults. APS staff members assess the need for protective services and provide services to reduce the identified risk to the adult.

Back-up Plan - A written plan that is a required component of a Member's PCSP , as applicable which specifies family members, other unpaid persons as well as Workers who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care or support in situations when regularly scheduled Workers are unavailable or do not arrive as scheduled. A Member shall not elect, as part of the Back-up Plan, to go without services. The Back-up Plan shall include the names and telephone numbers of persons to contact and the services to be provided by each of the listed contacts. The Member and his/her representative (as applicable) or for children in Katie Beckett the child's parent(s) or other legal guardian shall have primary responsibility for the development and implementation of the Back-up Plan for Consumer-Directed or Self-Directed services, as applicable. The Contractor will assist as needed with the development and verification of the initial Back-up Plan. The Care Coordinator, Support Coordinator, Nurse Care Manager, or DIDD Case Manager, as applicable, shall be responsible for assistance as needed with implementing the Back-up Plan and for updating and verifying the Back-up Plan on an ongoing basis.

Budget Authority – An HCBS self-directed model that allows participants to hire, fire, and supervise personal support workers (e.g., personal care attendants, homemakers), as well as use their funds to purchase other goods and services designed to meet disability-related needs and, in the case of people with psychiatric disabilities, recovery-related supports.

Care Coordinator - For purposes of CHOICES, a person who is employed or contracted by an MCO to perform the continuous process of care coordination:

(a) Assessing a Member's physical, behavioral, functional, and psychosocial needs;

(b) Identifying the physical health, behavioral health, and long-term services and supports (LTSS) and other social support services and assistance (e.g., housing or income assistance) necessary to meet identified needs;

(c) Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and LTSS services needed to help the Member maintain or improve his physical or behavioral health status or functional abilities and maximize independence; and

(d) Facilitating access to other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

Caregiver - For purposes of CHOICES and ECF CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or ECF CHOICES or for consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES. For purposes of Part A of the Katie Beckett Program, the "caregiver" is generally the child's parent(s) or other legal guardian except when someone other than the child's parent(s) or other legal guardian are routinely involved in providing unpaid support and assistance to the child.

Child Protective Services (CPS) – A program division of the Tennessee Department of Children's Services whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

Complaint System – A system established and maintained by the Contractor for responding to and tracking verbal and written complaints from Members/Representatives and Workers regarding dissatisfaction with any action or omission of the Contractor or the Contractor's staff.

Comprehensive Aggregate Cap Waiver (CAC) — A HCBS Waiver (Control Number TN 0357) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves individuals with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), persons discharged from the Harold Jordan Center following a stay of at least 90 days, and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are individuals who have been institutionalized in a public institution, were part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The CAC Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver member's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Confidential Information – Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is created under this Contract. Any such information relating to Members or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained under this Contract, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under State and federal laws or regulations. All Confidential Information shall not be subject to disclosure under the Tennessee Public Records Act.

Consumer-Directed or Self-Directed Worker (Worker) – An individual who has been hired by a Member/Representative, or by a parent or other legal guardian of a Katie Beckett member to provide one or more Eligible CHOICES HCBS, Eligible ECF CHOICES HCBS, Eligible Katie Beckett HCBS, or Eligible 1915(c) Waiver Program HCBS to the Member. Worker does not include an employee of an agency that is being paid by an MCO or DIDD to provide HCBS to the Member.

Consumer Direction of Eligible CHOICES or ECF CHOICES HCBS (Consumer Direction) - The opportunity for a CHOICES or ECF CHOICES Member assessed to need specified types of CHOICES or ECF CHOICES, HCBS including for purposes of CHOICES, attendant care, personal care, in-home respite, companion care; for purposes of ECF CHOICES, personal assistance, supportive home care, hourly respite, and community transportation; and/or any other service specified in TennCare Rules as available for Consumer Direction to elect

to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of Consumer-Directed workers delivering the needed service(s), for ECF CHOICES, the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service, and for Katie Beckett, the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service.

Consumer Direction of Eligible Katie Beckett HCBS - The opportunity for the parent or other legal guardian of a child enrolled in Katie Beckett Part A assessed to need specified types of Katie Beckett HCBS as set forth in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or in limited circumstances to have a representative direct and manage) certain aspects of the provision of such services – primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service. Eligible Katie Beckett HCBS do not include home health or private duty nursing services.

Consumer-Direction of Eligible 1915(c) Comprehensive Aggregate Cap/Statewide Waiver HCBS– The opportunity for a CAC or SWW Member assessed to need specified types of HCBS, limited to personal assistance, respite, and community transportation; or any other service approved by CMS and specified in TennCare Rules as available for Consumer to elect to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of Consumer-Directed workers delivering the needed service(s), including, the delivery of each eligible CAC Waiver or SWW HCBS within the authorized budget for that service.

Contract Provider - A provider who is under contract with the Contractor. Also called “Network Provider” or “In-Network provider.”

Contractor Risk Agreement – The agreement between MCOs and TennCare regarding requirements for operation and administration of the TennCare managed care program, including CHOICES and ECF CHOICES.

Credible Allegation of Fraud – An allegation of fraud which has been evaluated by the State, using information from any source, including:

- Fraud hotline complaints,
- Claims data mining, and/or
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judicially on a case-by-case basis. (42 CFR 455.2) TCR 1200-13-18-.02(11).

Department of Intellectual and Developmental Disabilities Case Manager (Case Manager) - A qualified individual employed by DIDD who provides support coordination services to members in the Self-Determination Waiver and is responsible for the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities enrolled in the program to identify and achieve individualized goals related to work (in competitive, integrated employment), personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness as specified in the Person-Centered Support Plan (PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider’s performance in supporting the person’s achievement of these goals.

Eligible CHOICES HCBS - For purposes of Consumer Direction, CHOICES HCBS that may be Consumer-Directed are limited to attendant care, personal care, in-home respite, or companion care services and/or any other CHOICES HCBS specified in TennCare Rules and regulations as eligible for Consumer Direction for which a CHOICES Member is determined to need and elects to direct and manage (or have a Representative direct and manage). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Eligible ECF CHOICES HCBS - For purposes of Consumer Direction, ECF CHOICES HCBS that may be Consumer-Directed are limited to personal assistance, supportive home care, hourly respite, community transportation, and/or any other ECF CHOICES HCBS specified in TennCare Rules as eligible for Consumer Direction which an ECF CHOICES Member is determined to need and elects to direct and manage (or have a Representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of Consumer-Directed workers delivering the needed service(s) and the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service. Eligible ECF CHOICES HCBS do not include home health or private duty nursing services.

Eligible Katie Beckett HCBS - Respite, Supportive Home Care, Community Transportation and any other Katie Beckett HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a Katie Beckett member is determined to need and which the member's parent or other legal guardian elects to direct and manage (or in limited circumstances to have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and, as applicable, the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service. Eligible Katie Beckett HCBS do not include home health or private duty nursing services.

Eligible 1915(c) Comprehensive Aggregate Cap/Statewide Waiver Program HCBS - For purposes of Consumer-Direction, Eligible 1915(c) CAC or SWW Program HCBS that may be Consumer-Directed are limited to respite services, personal assistance, and community transportation services.

Eligible 1915(c) Self-Determination Waiver Program HCBS - For purposes of Self-Direction, Eligible 1915(c) Waiver Program HCBS that may be Self-Directed are limited to respite services (when provided by an approved respite provider who serves only one (1) Member), personal assistance; day services (except those selected by and provided in a facility-based setting); and individual transportation services.

Employer Authority – An HCBS self-directed model that allows participants to hire, fire, and supervise personal support workers (e.g., personal care attendants, homemakers), but does not allow the participant to use their funds for any other goods or services.

Employer of Record – The Member or a Representative designated by the Member to assume the Consumer Direction or Self-Direction functions on the Member's behalf or the parent or other legal guardian of a Katie Beckett member participating in consumer direction of eligible Katie Beckett HCBS. In limited circumstances, the parent or legal guardian of a child in Katie Beckett may delegate a representative for consumer direction.

Electronic Visit Verification (EVV) Compliance – The consistent use of an electronic visit verification method when checking in and out of visits.

False Claims Act - A federal law that creates civil liability for any person or organization that knowingly files a false claim (1902(a)(68) of the social security act) or makes a false record seeking payment from the U.S. government services or supplies. The State of Tennessee has a similar statute, the Tennessee Medicaid False Claims Act that only applies to false claims submitted under the state's Medicaid program. 31 U.S.C. 2739; T.C.A. 71-5-181 through 71-5-184.

Fiscal Employer Agent (Contractor) – An entity contracting with the State, MCOs, and/or DIDD that helps Members in Consumer Direction and Self-Direction. The Contractor provides both Financial Administration and Supports Brokerage functions for Members. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Revenue Procedure 2013-39 as the agent to Members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The Contractor also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the Eligible CHOICES HCBS, Eligible ECF CHOICES HCBS, Eligible Katie Beckett HCBS, or Eligible 1915(c) Waiver Program HCBS, as applicable, authorized and provided.

Financial Administration - Financial Administration refers to the Contractor's functions related to the performance of payroll, employer taxes, and related tasks as defined in this Contract.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (see 42 C.F.R. 455.2).

HIPAA – Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HITECH -- Health Information Technology for Economic and Clinical Health Act of 2009. 42 U.S.C. § 300jj et seq. and 42 U.S.C. § 17921 et seq.

Home and Community-Based Services (HCBS) for Section 1915(c) Waiver, CHOICES and ECF CHOICES – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES, program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility.

Home and Community-Based Services (HCBS) for Katie Beckett - Specified wraparound services that are available only to eligible children enrolled in Katie Beckett Part A. Only certain Katie Beckett Part A HCBS are eligible for Consumer Direction. Katie Beckett Part A HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible children, although such services shall be counted for purposes of determining whether the cost of providing a Katie Beckett Part A member's needs at home will exceed the estimated Medicaid cost of institutional care.

Individual Support Plan (ISP) – An individualized written plan that identifies a Member's preferences, capacities, needs and resources and that identifies supports and services to meet such needs; and by which Members and their family are assisted to access the 1915(c) Waiver Program, Katie Beckett Part B and other necessary services. Effective September 1, 2021, these plans will be called Person Centered Plans (PCSPs).

Investigation - A review of a provider's services and/or claims submissions in response to a tip or allegation of potential or suspected fraud or abuse. Investigations shall include a retrospective review of claims and may be supplemented by provider and member interviews and provider research.

Katie Beckett Part A - One of two components of Tennessee's Katie Beckett Program that serves a limited number of children with the most significant disabilities or complex medical needs who meet institutional level of care, as established by TennCare, and who qualify for Medicaid only by waiving the deeming of parents' income and/or assets to the child. Children enrolled by TennCare into Katie Beckett Part A are eligible to receive all covered, medically necessary Medicaid benefits, including benefits provided under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as well as case management and specified wraparound home- and community-based services not otherwise covered by the Medicaid program, including respite. Part A will consist of children who are under age 18 who (1) have medical needs that are likely to last at least twelve months or result in death; and result in severe functional limitations based on medical eligibility criteria developed by TennCare specifically for children; (2) qualify for care in a medical institution; and (3) qualify for supplemental security income (SSI) due to the child's disability – except for the parent's income and/or assets. To qualify for (initial and continued) enrollment in Katie Beckett Part A, a licensed physician must agree and certify that in-home care will meet the child's needs, the cost of providing the child's care at home (including traditional Medicaid benefits and wraparound HCBS) cannot exceed the estimated Medicaid cost of institutional care, and the child cannot be Medicaid-eligible or receiving long-term services and supports in another Medicaid program. Katie Beckett Part A is administered by TennCare through its contracted MCO.

Katie Beckett Part A Member- A member who has been enrolled by TennCare into Part A of the Katie Beckett Program.

Katie Beckett Program Part B- One of two components of Tennessee's Katie Beckett Program that functions as a Medicaid diversion program and offers a capped package of wraparound services and supports as well as premium assistance on a sliding fee scale to a broader group of children with disabilities, including those "at risk" of institutionalization. Part B is an innovative, new approach that helps divert children from becoming Medicaid eligible by helping their families purchase private insurance and providing wraparound services and supports to meet the child's needs. Part B will consist of children who are under age 18 who (1) have medical needs that are

likely to last at least twelve months or result in death and result in severe functional limitations based on medical eligibility criteria developed specifically for children; (2) qualify for care in a medical institution or be "at-risk" of institutional placement; and (3) the child cannot be Medicaid eligible or receiving other long-term services and supports in another TennCare Medicaid program. Katie Beckett Part B is administered by DIDD.

Katie Beckett Part B Member – A person who has been enrolled by TennCare into Part B of the Katie Beckett Program.

Legal Guardian – For purposes of the Katie Beckett Program, the individual with physical custody of the child and the legal authority to make decisions concerning the child's protection, education, care, medical treatment, etc., including the child's PCSP for Katie Beckett. Generally, the child's parent(s) is the legal guardian except when guardianship has been otherwise established through court proceedings.

List of Excluded Individuals/Entities (LEIE) – List of Excluded Individuals/Entities is the database maintained by the Office of the Inspector General in the Department of Human Services containing the names of providers excluded from participation in federally financed healthcare programs by the authority granted in 42 U.S.C. § 1320a-7.

Managed Care Organization (MCO) – An appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term services and supports in the TennCare Program.

Member – Member shall mean an individual who is enrolled in CHOICES, ECF CHOICES, 1915(c) Waiver, or Katie Beckett and is Consumer-Directing/Self-Directing services under this Contract. The term collectively refers to CHOICES, ECF CHOICES, 1915(c) Waiver, and Katie Beckett Members when used in this Contract, unless a specific program is referenced (i.e., CHOICES Member, ECF CHOICES Member, 1915(c) Waiver Member, or Katie Beckett Member). As it relates to responsibilities pertaining to Consumer Direction in Katie Beckett , the term shall refer to the parent or other legal guardian of the child enrolled in Katie Beckett who has primary physical custody of the child and legal authority to make decisions on the child's behalf.

Modified Budget Authority – An HCBS self-directed model that allows participants to hire, fire, and supervise personal support workers (e.g., personal care attendants, homemakers), as well as use their funds, in a limited capacity, to purchase other goods and services designed to meet disability-related needs.

Nurse Care Manager – For purposes of the Katie Beckett Program Part A, a person who is employed and contracted by an MCO to perform responsibilities related to the continuous engagement and management of:

(a) Assessing a child's strengths, physical and behavioral health and long-term services and supports needs, goals and challenges;
(b) Identifying the services and supports (including unpaid supports voluntarily provided by family members and other caregivers, and paid services provided by private insurance, the MCO, and other payor sources) that will be provided to the child to meet the child's physical and behavioral health and long-term services and supports needs, and support the child in achieving his or her individualized goals;
(c) Working closely with providers in implementing the Integrated Plan of Care. Long-term services and supports identified through nurse care management and provided by the MCO shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, service that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or private insurance;
(d) Developing and maintaining for each member, through a person and family centered planning process, an individualized, plan of care. The child should be involved in helping define his or her individualized goals and develop the plan of care the maximum extent possible and appropriate. This planning process, and the resulting person and family centered plan of care shall: 1) ensure the delivery of services in a manner that reflects the family's strengths, needs, preferences and choices; 2) assists the child in achieving personally defined outcomes in the most integrated community setting, which shall include planning and preparation for the child's transition to employment and community living with as much independence as possible upon becoming an adult; and 3) help to engage, strengthen, support and build the capacity and confidence of the family in order to ensure the child's safety, well-being and permanency;

(e) ensuring timely access to and provision, coordination and monitoring of covered physical and behavioral health services and wraparound HCBS; and
(f) collaboration between providers and payors of the member's physical and behavioral health services and wraparound HCBS, including physicians, other physical and behavioral health care providers, HCBS providers, TennCare, DIDD, the local education authority, Vocational Rehabilitation, and the MCO to facilitate seamless access to care and maximize health and quality of life outcomes, and to plan and prepare for the child's transition to employment and community living with as much independence as possible upon becoming an adult.

Office of Attorney General Medicaid Fraud and Integrity Division (AG/MFID) - The division of the State of Tennessee that is responsible for civil prosecution of violations of the Tennessee Medicaid False Claims Act.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud, waste, and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

Office of Program Integrity (OPI) - The State Medicaid Agency unit responsible for the prevention, detection and investigation of alleged provider fraud, waste, and abuse of the TennCare program.

Person-Centered Practices - An approach to the performance of functions required under this Contract by the Contractor and its staff that focuses on the goals, preferences and needs of the Member seeking assistance, and which supports the Member's choice and self-determination, which includes:

(a) Ensuring that the Contractor allows people chosen by the Member/Representative to be present for discussion about Consumer Direction or Self-Direction, as applicable;
(b) Provides the Member/Representative with necessary information and support to ensure the Member/Representative directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
(c) Required meetings with Members/Representatives are timely and occur at times and locations of convenience for the Member/Representative;
(d) Reflects cultural considerations of the Member/Representative and is conducted by providing information in plain language and in a manner accessible for individuals with disabilities and individuals who are limited English proficient; and
(e) The Contractor and its staff have strategies for solving conflict or disagreement.

Person-Centered Support Plan (PCSP) - As it pertains to CHOICES, ECF CHOICES, and the 1915(c) Waiver Program, the PCSP is a written plan developed by the Support Coordinator, Care Coordinator, or DIDD Case Manager in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the member's MCO and other payor sources. The person-centered planning process is directed by the member with long-term support needs and may include a representative whom the member has freely chosen to assist the member with decision-making, and others chosen by the member to contribute to the process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the individual, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. This planning process, and the resulting PCSP, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. Services in CHOICES, and ECF CHOICES shall be authorized, provided, and reimbursed only as specified in the PCSP.

As it pertains to Part A of the Katie Beckett Program, the plan of care is a written document developed by the Nurse Care Manager in accordance with this Contract and in a manner consistent with federal regulation, and in TennCare

policies and protocols, through a person- and family-centered planning process that assesses the child's strengths, needs, goals and challenges; and outlines the services and supports (including unpaid supports voluntarily provided by family members and other caregivers, and paid services provided by private insurance, the MCO, and other payor sources) that will be provided to the child to meet the child's physical and behavioral health and long-term services and supports needs and support the child in achieving his or her individualized goals. The child should be involved in helping to define his or her individualized goals and develop the plan of care to the maximum extent possible and appropriate. This planning process, and the resulting person- and family-centered plan of care shall: 1) ensure the delivery of services in a manner that reflects the child and family's strengths, needs, preferences and choices; 2) assist the child in achieving personally defined outcomes in the most integrated community setting, which shall include planning and preparation for the child's transition to employment and community living with as much independence as possible upon becoming an adult;, and 3) help to engage, strengthen, support, and build the capacity and confidence of the family in order to ensure the child's safety, well-being and permanency. Services in the Katie Beckett Program shall be authorized, provided, and reimbursed only as specified in the plan of care.

For purposes of CHOICES and Part A of the Katie Beckett Program, "plan of care" shall be used interchangeably with "person-centered support plan" or "PCSP."

Provider - Provider shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:

(a) Participating Providers or In-Network Providers
(b) Non-Participating Providers or Out-of-Network Providers
(c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in TennCare Rule 1200-13-13-.01.
Provider does not include Consumer-Directed Workers (See Consumer-Directed Worker); nor does provider include the Contractor (Fiscal Employer Agent).

Reportable Event - For purposes of CHOICES, ECF CHOICES, Katie Beckett, and the 1915(c) Waiver Programs, a Reportable Event is an event that is classified as Tier 1, Tier 2, or Additional Reportable Events, as defined by TennCare, that the contracted provider, MCO, or Contractor shall be responsible for reporting to the Member's MCO, DIDD, law enforcement, and/or APS or CPS, as appropriate, within the timeframes and in the manner as specified by TennCare .

Representative – As it relates to Consumer Direction in the 1915(c) Comprehensive Aggregate Cap and Statewide Waivers, CHOICES and ECF CHOICES, and Self-Direction in the 1915(c) Self-Determination Waiver Program, a person who is authorized by the Member to serve as the Employer of Record, and to direct and manage the Member's Worker(s), and signs a Representative agreement. As it relates to Katie Beckett, the parent or other legal guardian of a Katie Beckett member will generally serve as the Employer of Record, but may authorize a representative for consumer direction in limited circumstances. The child cannot assume Consumer Direction or Self-Direction functions or authorize a Representative to perform such functions. The Representative for Consumer Direction or Self-Direction must also: be at least eighteen (18) years of age; have a personal relationship with the Member and understand his/her support needs; know the Member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate Workers.

Representative Agreement – The agreement between a Member electing Consumer Direction or Self-Direction, as applicable, who has a Representative direct and manage the Members' Worker(s) and that specifies the roles and responsibilities of the Member and the Member's Representative.

Self-Direction of Eligible 1915(c) Self-Determination Waiver Program HCBS (Self-Direction) - The opportunity for a Member in the 1915(c) Self-Determination Waiver assessed to need specified types of Self-Directed services, including personal assistance, community-based day services, respite, transportation, and/or any other service specified in TennCare Rules as available for Self-Directed service option to elect to direct and

manage (or to have a Representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of Self-Directed Workers delivering the needed service(s) and the delivery of eligible HCBS within the authorized budget for such services.

Self-Direction of Health Care Tasks – A decision by a Member or the parent or other legal guardian of a Katie Beckett member in Consumer Direction or Self-Direction to direct and supervise a paid Worker delivering Eligible CHOICES HCBS, Eligible ECF CHOICES, Eligible Katie Beckett HCBS, or Eligible 1915(c) Waiver Program HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-Direction of health care tasks is not a service, but rather, health care-related duties and functions (such as administration of medications) that a Member in Consumer Direction or Self-Direction or the parent or other legal guardian of a child enrolled in Katie Beckett may elect to have performed by a Consumer-Directed or Self-Directed Worker as part of the delivery of Eligible CHOICES HCBS, Eligible ECF CHOICES HCBS, Eligible Katie Beckett HCBS, or Eligible 1915(c) Waiver Program HCBS s/he is authorized to receive.

Self-Determination Waiver Program - A Home and Community Based Services (HCBS) Waiver (Control Number TN 0427) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves children and adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Self-Determination Waiver Program affords Members the opportunity to directly manage selected services, including the recruitment and management of service providers. Members and families (as appropriate) electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery. The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living. The Self-Determination Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Service Agreement – The agreement between a Member/Representative electing Consumer Direction or Self-Direction and the Worker that specifies the roles and responsibilities of the Member/Representative and the Worker and the Worker's rate of pay.

Statewide Waiver - A HCBS Waiver (Control Number TN 0128) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves children and adults with intellectual disabilities and children under age six with a developmental disability who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Statewide Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Support Coordinator (CAC & Statewide Waiver) – For purposes of CAC & Statewide Waiver members, a qualified individual employed by a Support Coordination provider agency contracted with one or more MCOs to provide support coordination services to members in the Statewide or CAC Waivers and is responsible for the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities enrolled in the program to identify and achieve individualized goals related to work (in competitive, integrated employment), personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness as specified in the Person-

Centered Support Plan (PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider's performance in supporting the person's achievement of these goals.

Support Coordinator (ECF CHOICES) – For purposes of ECF CHOICES, a person who is employed or contracted by an MCO to perform responsibilities related to the continuous process of:

(a) identifying, developing, and supporting opportunities for a Member's community involvement, including achieving and maintaining competitive, integrated employment consistent with the Member's individual strengths, preferences and conditions for success;
(b) leveraging Member strengths, resource and opportunities available in the Member's community, and natural supports available to the Member in coordination with ECF CHOICES services and supports to enable the Member to achieve his/her desired lifestyle and goals for community involvement, employment and independent living and wellness;
(c) assessing a Member's physical, behavioral, functional, and psychosocial needs;
(d) identifying the physical health, behavioral health and long-term services and other support services and assistance (e.g., vocational rehabilitation, housing or income assistance) that are necessary to enable the Member to achieve his/her desired lifestyle, goals for community involvement, employment and independent living, and wellness, and to address identified needs;
(e) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term services and supports necessary to facilitate the Member's community involvement, including achieving and maintaining competitive, integrated employment, consistent with the Member's individual strengths, preferences and conditions for success and necessary to maintain or improve his or her physical or behavioral health status and functional abilities, to maximize independence, to ensure the Member's rights and choices, health, safety and welfare, and as applicable, to delay or prevent the need for more restrictive and more expensive institutional placement; and
(f) facilitating access to other support services and assistance the Member needs to achieve his/her desired lifestyle, goals for community involvement, employment and independent living and wellness, and to address identified needs.

Supports Broker - An individual assigned by the Contractor to each Member who assists the Member/Representative as requested by the Member/Representative in performing certain Employer of Record functions as follows: developing job descriptions; recruiting, interviewing, and hiring Workers; Member and Worker enrollment in Consumer Direction and Consumer Direction training or Self-Direction and Self-Direction training, as applicable; and developing (as part of the onboarding process for new Workers) a schedule for the Member's Workers that comports with the schedule at which services are needed by the Member as reflected in the Member's or Person's Supported PCSP, as applicable. The Supports Broker shall also assist the Member as needed with developing and verifying the initial Back-up Plan. The Supports Broker collaborates with the Member's Care Coordinator, Support Coordinator, Nurse Care Manager, or DIDD Case Manager, as applicable and appropriate. The Supports Broker does not have authority or responsibility for Consumer Direction or Self-Direction. The Member/Representative must retain authority and responsibility for Consumer Direction or Self-Direction, as applicable.

TennCare or TennCare Program – The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare CHOICES in Long-Term Services and Supports (CHOICES) – A program in which all nursing facility services and home and community based long-term services and supports for the elderly and/or adults with physical disabilities are integrated into TennCare's managed care delivery system.

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

TennCare Katie Beckett Program (Katie Beckett) – A program which offers Medicaid-reimbursed assistance to a specified number of eligible children under age 18 1) who have complex medical needs and/or disabilities; 2)

would qualify for SSI and for Medicaid if institutionalized; 3) do not otherwise qualify for Medicaid because of the parents' income or assets; and 4) for whom the cost of services in the home is less than or equal to the cost of services in an institutional setting.

Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Division has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud, waste, and abuse in board and care facilities.

Timekeeping System - A system developed, implemented, and maintained by the Contractor to capture time submitted for the delivery of Consumer-Directed and Self-Directed services. The system is used to monitor Member receipt of Eligible CHOICES HCBS, Eligible ECF CHOICES HCBS, and Eligible 1915(c) Waiver Program HCBS to ensure provided HCBS is authorized by the MCO or DIDD, as applicable, generate payment to Workers for hours worked, as appropriate, and also generate claims for submission by the provider. The system will not allow payment to Workers for services not authorized by the MCO or DIDD, as applicable.

Vital Documents – Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension, or termination of services, certain critical outreach documents (i.e., case management and Population Health documents) and any other documents designated by the State. At a minimum, all vital documents shall be available in the Spanish language.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Waste - Is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1915(c) Waiver Program – One of the three waivers (Statewide, Comprehensive Aggregate Cap, and Self-Determination) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act to which provide HCBS not otherwise available under the State Plan to eligible persons with I/DD enrolled in such waivers.

7. **Delete Pro Forma Section A.87.d in its entirety and insert the following in its place** (any sentence or paragraph containing revised or new text is highlighted)**:**

   d. As appropriate, train Contractor's staff on how to use the EVV solution and requirements for Electronic Visit Verification Compliance and monitoring;

8. **Add a new Section A.104 and insert the following paragraph** (any sentence or paragraph containing revised or new text is highlighted)**:**

   A.104 The Contractor shall obtain and maintain in full force and effect for the duration of this contract, the types and minimum limits of insurance as required by state and federal law including, but not limited to, Workers' Compensation and Employer Liability Insurance for the Contractor's services and employees. This provision does not apply to consumer directed or self-directed workers who provide services to Participants.

9. **Add a new Section A.105 and insert the following paragraph** (any sentence or paragraph containing revised or new text is highlighted)**:**

A.105 The Contractor shall maintain a financial reserve equal to one month's payroll and administrative expenses funder this Contract.

10. **RFP Amendment Effective Date.** The revisions set forth herein shall be effective upon release. All other terms and conditions of this RFP not expressly amended herein shall remain in full force and effect.

EXHIBIT A

INVOICE

Logo Name

INVOICE DATE
Date

INVOICE NO
Number

REMIT TO
Company Name
City, ST ZIP Code
Contact Name
Phone
Email

INVOICE TO
CONTACT NAME
Street Address
City, ST ZIP Code
Email

CONTRACT # 123456	PAYMENT TERMS: NET 30
DATE OF SERVICE (FROM/TO)	

QUANTITY	DESCRIPTION	UNIT PRICE	LINE TOTAL
#	Service Description	$Amount	$Amount
#	Service Description	$Amount	$Amount
#	Service Description	$Amount	$Amount
#	Service Description	$Amount	$Amount
		TOTAL	$Amount

EXHIBIT B

Title	Description	Deliverable Occurrence	Due Date	TennCare Business Area	Reporting Type
A.104 - Weekly EVV Compliance	Report that provides Timesheet Submission totals by providers for each MCO, broken down by EVV totals and Non EVV totals	Weekly	Every Tuesday	LTSS	Statewide
A.104 - Weekly Katie Beckett EVV Compliance	Report that provides Timesheet Submission totals by providers for each MCO, broken down by EVV totals and Non EVV totals for Katie Beckett	Weekly	Every Tuesday	LTSS	Statewide
A.56 - Annual Customer Satisfaction Report	A survey of participating members/ representatives to determine satisfaction with participation in consumer direction	Annually	March 30th	LTSS	Statewide
A.56 - Annual Katie Beckett Customer Satisfaction Report	A survey of participating Katie Beckett members/ representatives to determine satisfaction with participation in consumer direction	Annually	March 30th	LTSS	Statewide
A.74.a - Weekly Pre Enrollment Referral and Enrollment Report	Member, Support Broker, and timeline of enrollment and worker start	Weekly	Every Friday	LTSS	Statewide
A.74.b - Monthly Consumer Direction and Self-Direction Count Report	Active referrals for CD, active authorizations for CD and Companion Care	Monthly	1st of month	LTSS	Statewide
A.74.b - Monthly Katie Beckett Consumer Direction and Self-Direction Count Report	Active referrals for CD, active authorizations for CD and Companion Care for the Katie Beckett Program	Monthly	1st of month	LTSS	Statewide
A.74.c - Quarterly Supports Broker Report	Turnover rate, broker-to-member ratio, reassignments, and current case status	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide

A.74.c - Quarterly Katie Beckett Supports Broker Report	Turnover rate, broker-to-member ratio, reassignments, and current case status for Katie Beckett	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.d - Monthly EVV Compliance by Member	Members, Worker and no. of compliant visit verification methods	Monthly	20th of the following month	LTSS	Statewide
A.74.d - Monthly Katie Beckett EVV Compliance by Member	Members, Worker and no. of compliant visit verification methods for Katie Beckett	Monthly	20th of the following month	LTSS	Statewide
A.74.e - Monthly Fraud, Waste, and Abuse Report	The Contractor shall develop and submit a monthly Fraud, Waste, and Abuse Report on the issues identified and tracked through the Contractor's fraud, waste, and abuse system and the resolution and timeframes for resolution of identified issues by program, including whether the Contractor took any action on fraud, waste, and abuse tips or provided any education on the incidents relating to the tips. The report shall be submitted through the TennCare tracking system by the 5th of each month.	Monthly	5th of each month	LTSS	Statewide
A.74.f.1 - Quarterly Complaint Report	Member/representative, worker, and CC/SC/CM complaints and the resolution and timeframe	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.1 - Quarterly Katie Beckett Complaint Report	Member/representative, worker, and NCM complaints and the resolution and timeframe for Katie Beckett	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.2 - Quarterly Referral and Enrollment Report	Identifying number of referrals, enrollments, withdrawals and length of days between referral and service initiation	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide

A.74.f.2 - Quarterly Katie Beckett Referral and Enrollment Report	Identifying number of referrals, enrollments, withdrawals and length of days between referral and service initiation	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.3 - Quarterly Customer Service Report	Determining call center service by number of calls, hold time, return phone calls	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.3 - Quarterly Katie Beckett Customer Service Report	Determining call center service by number of calls, hold time, return phone calls	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.4 - Quarterly Participant Utilization Report	Authorized service and rate information for members enrolled in consumer direction	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.4 - Quarterly Katie Beckett Participant Utilization Report	Authorized service and rate information for members enrolled in consumer direction	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.4 - Annual Participant Utilization Report	Authorized service and rate information for members enrolled in consumer direction	Annually	March 30th	LTSS	Statewide
A.74.f.4 - Annual Katie Beckett Participant Utilization Report	Authorized service and rate information for Katie Beckett members enrolled in consumer direction	Annually	March 30th	LTSS	Statewide

A.74.f.5 - Quartlery Worker Report	Workers who provided services to more than three (3) people	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.6 - Quarterly TN Tax Liabilities Report	How much tax liability is owed and paid for CD Members	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.6 - Quarterly Katie Beckett TN Tax Liabilities Report	How much tax liability is owed and paid for Katie Beckett CD Members	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.7 - Quarterly Participant Advocacy Group Report	Name, location, and time of most recent quarterly advocacy group meeting to include a list of participants	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.7 - Quarterly Katie Beckett Participant Advocacy Group Report	Name, location, and time of most recent quarterly Katie Beckett advocacy group meeting to include a list of participants	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.8 - Monthly Reportable Event Report	Number of reportable events overall and by Tier and type of event. Monthly Report per the memo shared on 5/4/2022.	Quarterly	Last day of the month	LTSS	Statewide

A.74.f.8 - Monthly Katie Beckett Reportable Event Report	Number of reportable events overall and by Tier and type of event for the Katie Beckett Program Monthly Report per the memo shared on 5/4/2022.	Quarterly	Last day of the month	LTSS	Statewide
A.74.f.9 - Quarterly Accounts Receivable Report	a. The total number and amount of denied claims by MCO, both those that the Contractor determined were appropriately and inappropriately denied (these shall be identified separately); b.Inappropriately denied claims and amounts, date of submission, reason(s) for denial with corresponding code; and the status and/or date of resolution; c.Reason(s) for denial of appropriately denied claims with corresponding code, including the number of claims appropriately denied for each reason; d.Actions taken toward addressing appropriately denied claims (i.e., to minimize denied claims going forward); and e.additional ad hoc reports shall be prepared and submitted as directed by TennCare at a frequency mutually agreed upon by the Contractor and TennCare.	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide
A.74.f.9 - Quarterly Katie Beckett Accounts Receivable Report	A for Katie Beckett report that provides denial information and what the reason for denials were.	Quarterly	April 30th - Q1 July 30th - for Q2 Oct 30th - for Q3 Jan 30th for Q4	LTSS	Statewide