

FEB 27 2007

RFS-343

MEDICAID/TITLE V AGREEMENT

TENNESSEE DEPARTMENT OF HEALTH

1. BUREAU OF HEALTH SERVICES

2. BUREAU OF HEALTH SYSTEMS DEVELOPMENT

3. BUREAU OF MEDICAID

and

4. TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

TABLE OF CONTENTS

- I. Parties to the Agreement
- II. Content of the Agreement
 - A. Mutual objectives and responsibilities of each party
 - B. Services each party offers
 - C. Parties involved in cooperative and collaborative relationships at the state level
 - D. Services covered by the agreement
 - E. Method for early identification of individuals under age 21
 - F. Method for reciprocal referrals
 - G. Method for coordinating plans for health services
 - H. Method for reimbursement
 - I. Method for exchange of reports of services furnished to recipients
 - J. Method for periodic review and joint planning for changes in the agreement
 - K. Continuous liaison among the parties
 - L. Joint evaluation of policies
- III. Timeframe of the Agreement
- IV. Appendixes
 - A. Intradepartmental agreement for EPSDT outreach
 - B. Intradepartmental agreement between the Bureau of Health Services and the Bureau of Medicaid
 - C. Interdepartmental agreement between the Department of Health and the Department of Finance and Administration
 - D. Presumptive Eligibility Provider Agreement
 - E. Title V providers

I. Parties to the agreement:

42 CFR 431.615. and the Social Security Act. Section 1902 (a) 11 (Title XIX). And Section 513 (c) (Title V), set forth the requirement for a collaborative agreement between the State Title V Agency and the State Title XIX Agency. Since the Tennessee Department of Health is the single state agency for both funding sources, this agreement outlines the relationships along the three organizational units of the Department having distinct responsibilities in the provision of Title V services. These units are the Bureau of Health Services, the Bureau of Health Systems Development, and the Bureau of Medicaid.

- A. The Bureau of Health Services is responsible for program planning, policies, and operational Management of the Title V program. It has organizational responsibility for the state's 95 county health departments.
- B. The Bureau of Health Systems Development is responsible for assessing primary health care needs across the state, developing linkages, and designing systems to improve access to care. It has organizational responsibility for the state's 12 Community Health Agency regions.
- C. The Bureau of Medicaid is responsible for policies, planning, and management of the Medicaid Program.

II. Content of the agreement:

A. Mutual objectives and responsibilities of each party

- 1. General objective - To insure that Title V available and used to the maximum extent possible by mothers and children in Tennessee.
- 2. Intradepartmental agreement for EPSDT Outreach (See Appendix A)
- 3. MCH Objectives
 - a. To assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;
 - b. To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children;
 - c. To reduce the need for inpatient and long-term care services;
 - d. To increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low income children, and prenatal, delivery, and postpartum care for low income mothers);
 - e. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI of the Social Security Act, to the extent medical assistance for such services is not provided under Title XIX;
 - f. To provide care coordination services as well as medical, surgical, and corrective services to children with chronic diseases and/or handicapping conditions; and

- g. To assist in providing a statewide, uniform assessment process designed to address the needs of children identified by the Bureau of Health Systems Development and to assist in providing for the services identified by the assessment.

4. Responsibilities

- a. The Bureau of Health Services will maintain a clinical health care delivery system capable of providing Medicaid covered services to the Medicaid-eligible population and to provide additional Title V services which are not covered by the Medicaid Program to Medicaid-eligibles.
- b. The Bureau of Health Systems Development will provide assistance in assuring adequate access to care and will coordinate assessments needed by children identified and the provision of services determined to be needed as a result of these assessments.
- c. The Bureau of Medicaid will recognize the Bureau of Health Services as the agency responsible for the provision of Title V services and will accept its designation of agencies that will provide Title V services under this agreement. (See Appendix B) Payment to the designated agencies will be made in accordance with the interagency agreement between the Department of Health and the Department of Finance and Administration, where appropriate.
- d. The Bureau of Medicaid at the request of the Title V agency will reimburse the Title V agency for all services provided under this agreement. This reimbursement may be made directly to the Title V agency or to the designated Title V provider, or it may be made for the Title V agency through the interagency agreement between the Department of Health and the Department of Finance and Administration incorporated as part of this agreement. (See Appendix C.)

B. Services each party offers

1. The Bureau of Health Services offers a broad array of primary and preventive care services, including care coordination for pregnant women and high risk children to age 2 and EPSDT outreach. Special areas of emphasis include prenatal services, well child services, and assistance for children with special needs. These services are either provided by the Bureau or arranged and coordinated by the Bureau.
2. The Bureau of Health Systems Development offers expertise in designing health care systems to assure access, as well as providing assessments and care coordination services for identified children.
3. The Bureau of Medicaid provides reimbursement for Medicaid-covered services in accordance with stated policies and procedures.

C. Parties involved in cooperative and collaborative relationships at the state level

1. Bureau of Health Services
C1-100 Cordell Hull
Nashville, Tennessee 37247-4501
2. Bureau of Health Systems Development
5th Floor, Cordell Hull
Nashville, Tennessee 37247-4501

3. Bureau of Medicaid
729 Church Street
Nashville, Tennessee 37247-6501

4. Department of Finance and Administration
1st Floor, State Capitol
Nashville, Tennessee 37243-0285

D. Services covered by the agreement

1. Services that are Title V in nature outlined in the Medicaid State Plan provided by units of the Department of Health or by other designated Title V providers.
2. Preventive health counseling services, which shall be limited to a maximum of 24 preventive health counseling visits per recipient per year.
3. Presumptive Medicaid eligibility determinations for pregnant women, in accordance with all applicable federal and/or state guidelines governing such program. (See Appendix D for an exhibit of the Presumptive Eligibility Provider Agreement entered into between the Bureau of Health Services and the Bureau of Medicaid).
4. Newborn laboratory screening services, including hemoglobinopathy, hypothyroid and PKU.
5. Family planning services as defined and outlined in the "Tennessee Family Planning Standards, Guidelines and Procedures Manual."
6. Speech and hearing services, including diagnostic and rehabilitative services, for Medicaid eligible recipient's ages 0-21 who have problems of communication with either conductive or sensorineural hearing losses and children with speech/language problems. In accordance with existing policy, the Bureau of Health Services will bill Medicaid on behalf of the speech and hearing centers for speech and hearing services and materials provided by such centers to Medicaid eligible children.
7. Assessments, case management services, and other Medicaid covered Services provided for children identified by the Bureau of Health Systems Development.
8. A toll free number to assist pregnant women in obtaining needed services, maintained by MCH
9. Development of special support services for pregnant teenagers and their infants through use of trained community Resource Mothers. These services will be developed initially by the Bureau of Health Services through pilot projects in selected urban and rural counties identifies as having a high incidence of morbidity and mortality related to teen mothers and infants.
10. Children's therapeutic intervention services, as determined to be needed for identified children by the Bureau of Health Systems Development.

E. Method for early identification of individuals under age 21

1. Early identification will be accomplished by:
 - a. Referrals from community agencies, private health care providers and hospitals,
 - b. Referrals from Social Security (SSI).
 - c. Referrals from other state agencies. i.e., DHS, Vocational Rehabilitation, Mental Health and Mental Retardation.
 - d. Referrals from Juvenile Court.

2. The Bureau of health Services will enhance its early identification efforts by developing Title V program guides describing available services and identifying service delivery sites.
3. Local health departments are charged with the responsibility of effective outreach and early identification by maintaining open access to clinical services by distributing program guides as required by maintaining liaison with local community agencies and private providers, and by maximizing the medical home concept.

F. Method for reciprocal referrals

1. Bureau of Health Services

- a. Has the responsibility of referring to Medicaid all Title V eligibles for Medicaid eligibility determination.
- b. Has the responsibility of providing the Department of Human Services materials/documents/program guides to be distributed to new Medicaid-eligibles informing them of the availability of Title V services.
- c. Has the responsibility of following up those Title V eligibles referred to Medicaid.

2. Bureau of Health Systems Development

- a. Has the responsibility of referring identified children to Medicaid to assure that eligibility determinations are done.
- b. Has the responsibility of following up those children referred to Medicaid.

3. Bureau of Medicaid

- a. Has the responsibility of informing all new EPSDT eligibles about the availability of Title V services.

G. Method for coordinating plans for health services

1. A Medicaid/Title V Advisory Committee will be established to coordinate plans to review standards, to monitor implementation of this agreement, and to review and update it as needed.
2. The Advisory Committee will meet at least annually or when any party requests that a formal meeting be conducted.
3. The Advisory Committee, at a minimum, will be comprised of:
 - a. Two representatives from the Bureau of Health Services
 - b. Two representatives from the Bureau of Health Systems Development
 - c. Two representatives from the Bureau of Medicaid
 - d. One representative from the Bureau of Administrative Services
4. The Chairman of the Advisory Committee will be appointed by the Commissioner of the Department of Health from among those representatives indicated in G.3.

- H. Method for reimbursement
 - 1. Designated Title V Providers
 - a. All Title V providers designated in Appendix E will be reimbursed at reasonable allowable cost, as determined by Medicare principles, for delivery of Title V services. The actual cost determination methods will be reviewed and approved by the Bureau of Administrative Services and the Bureau of Medicaid.
 - 2. Payment Procedures
 - a. Interim payment will be made to the Title V agency for services provided under this agreement in accordance with this agreement.
 - b. All individual Title V providers having been approved to be reimbursed at cost and for which a method to determine reasonable cost has been approved by the Bureau of Administrative Services will receive settlement in the appropriate amount. The amount of settlement shall be determined by the Bureau of Administrative Services and the Comptroller of the Treasury. Necessary cost data shall be collected according to Medicare principles of cost reimbursement for allowed and non-allowed cost as well as other applicable cost principles and submitted to the Bureau of Medicaid for verification and approval for payment. After approval, the request for settlement shall be forwarded to the Bureau of Administrative Services for payment.
- I. Method of exchange of reports of services furnished to recipients
 - 1. Services are to be provided directly by the Bureau of Health Services through its Regional Offices, local health departments, and other Title V providers within the State of Tennessee and by the Bureau of Health Systems Development through the Community Health Agencies within the State of Tennessee.
 - 2. All parties shall maintain strict confidentiality of patient medical records and other similar records in accordance with the law and established ethical standards, and written policies and procedures.
 - 3. All parties agree to establish accounting procedures, fiscal reporting and other records to assure proper accountability for fiscal transactions and for documentation of Title V services delivered to Medicaid eligibles.
 - 4. The books, records and documentation of the Bureau of Health Services, the Bureau of Health Systems Development, and other Title V providers insofar as they relate to work performed or money received under this agreement shall be maintained in conformity with generally accepted accounting principles for a period of three full years from the date of the final payment, and shall be subject to audit, at any reasonable time and upon reasonable notice by Medicaid or the Comptroller of the Treasury, or their duly appointed representative.
 - 5. All services delivered by Title V providers to Medicaid-eligibles shall be documented in the patient's medical record in accordance with current accepted and approved standards and practices.
 - 6. Data shall be collected and provided to meet the reporting requirements outlined in 42 USC 706(a).

- J. Method for periodic review and joint planning for changes in the agreement (See Section II. G. and L.)
- K. Continuous liaison among the parties (See Section II. G. and L.)
- L. Joint evaluation of policies

1. It will be the function of the Medicaid/Title V Advisory Committee to review periodically the tenets agreement with the aim of assuring:
 - a. that all Medicaid eligibles in need of Title V services receive the;
 - b. that appropriate fiscal documentation is ongoing;
 - c. that appropriate standards exist for Title V providers and Title V services;
 - d. that providers operate within stated policies;
 - e. that patient services are documented in accordance with accepted standards;
 - f. that information flows freely among all parties; and
 - g. that reimbursement/settlement at cost has occurred as indicated in this agreement.

III. Timeframe of the Agreement:

This agreement is a perpetual agreement and shall be reviewed annually by the Medicaid/Title V Advisory Committee or upon the request of any party to the agreement and amended as needed.

Approved:

W. Louis Moore, M.D.
Assistant Commissioner, Bureau of Health Services

Wendy Long, M.D.
Director, Bureau of Health Systems Development

Manny Martins
Assistant Commissioner, Bureau of Medicaid

Robert Maxwell
Assistant Commissioner, Bureau of Administrative Services

H. Russell White
Commissioner, Department of Health

David L. Manning
Commissioner, Department of Finance and Administration

Dated 10/1/92

IV. Appendixes

Appendix A: Intradepartmental Agreement for EPSDT Outreach

INTRA-DEPARTMENTAL AGREEMENT
BETWEEN
HEALTH SERVICES ADMINISTRATION AND
MEDICAID BUREAU

For
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT OUTREACH PROGRAM

This agreement is entered into by and between the HEALTH SERVICES ADMINISTRATION, hereinafter referred to as HSA and MEDICAID Bureau, hereafter referred to as Medicaid.

WHEREAS, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program was created by the 1967 Amendments to Title XIX to provide preventive health services and early detection and treatment of disease in children eligible for medical assistance, and

WHEREAS, the amendment requires state Medicaid programs to arrange for the screening of children under 21 years of age for physical and mental defects, and to provide the necessary health care to correct or ameliorate the defects, and

WHEREAS, Medicaid and HSA, both agencies of the Tennessee Department of Health, desire to enter into a cooperative agreement for the purpose of administering the outreach component of the EPSDT mandate.

WITNESSETH: In consideration of the mutual promises herein contained, the parties have, agreed and do hereby enter into this agreement according to the provisions set out herein:

I. SCOPE OF SERVICES:

A. Responsibilities of Medicaid

1. To act as a liaison with Federal and State officials and Medicaid screening providers regarding eligibility guidelines, screening services, outreach activities and implementation of the EPSDT Program.
2. To provide verbally and in writing and interpret, as needed to HSA, Federal and State policy and Regulations EPSDT Program in a timely manner.
3. To consult and review with HSA on regulations and recommendations which determine policy or direction of the EPSDT Program.
4. To provide an EPSDT computer subsystem for the purpose of tracking EPSDT eligibles and for documentation of input material supplied by screening providers and the outreach agencies.
5. To monitor and provide quality assurance of the EPSDT outreach process.

B. Responsibilities of Health Services Administration

1. To act as the primary outreach agency and to perform outreach activities statewide to ensure that all EPSDT eligibles are properly, informed in a timely manner of the EPSDT service available, how and where these services may be obtained.

2. To educate all EPSDT eligibles and potential eligibles and their families regarding the benefits of preventive health care and the importance of screening, diagnosis and treatment, and follow-up care. This will be accomplished through direct mailings from the State's fiscal agent, contact of EPSDT eligibles by EPSDT outreach workers, and public service announcements, health fairs, etc., by presentation of both printed and filmed material purchased and/or developed by Outreach Program personnel.
3. To provide all EPSDT eligibles, if requested, the necessary assistance for transportation services, and scheduling for screening, diagnosis and treatment as the EPSDT Outreach Manual.
 - a. Eligibles shall be telephoned for appointments and to determine if transportation services are needed.
 - b. Availability of transportation services shall be communicated to recipients by mail and/or telephone.
4. To provide the outreach activities as outlined in the EPSDT Outreach Manual through the following means:
 - a. Provision of outreach activities shall be routinely handled by mail and telephone.
 - b. In unusual cases a home visit may be made.
5. To provide the necessary documentation upon request by Medicaid and/or the federal auditors which shall include computer reports of outreach activities, follow-up services provided and expenditures.
6. To develop internal controls, information systems, and training for the effective implementation of all outreach activities.
7. To monitor and provide quality assurance of staff time, efforts, and expenditures involved .

II. COMPENSATION

- A. Medicaid shall reimburse HSA for actual expenditures incurred in performance of this agreement which are allowable and in accordance with the certified statement of expenditures which shall be submitted by HSA.
- B. Reimbursement shall be made on a monthly basis upon receipt by Medicaid of a request from HSA to journal voucher an amount of funds equal to the amount of expenditures incurred.
 1. The request for journal voucher shall be supported by an itemized list of expenditures by object code, the appropriate allotment code and budget cost center to receive the revenue funds.
 2. A state warrant shall be used to reimburse independent health departments, such as Metro Health Departments, in lieu of a journal voucher.
- C. In no event shall the liability of Medicaid under this agreement exceed \$2,639,470. This agreement is subject to the allotment and availability of State and Federal matching funds to finance the agreement activities.

III. ESSENTIAL TERMS AND CONDITIONS:

A. Records and Reports:

1. HSA shall maintain documentation for all charges against Medicaid under this agreement. The books, records and documentation of HSA, insofar as they relate to work performed or money received under this agreement, shall be maintained in conformity with generally accepted accounting principles for a period of three full years from the date of the final payment, and shall be subject to audit, At any reasonable time and upon reasonable notice, by Medicaid or the Comptroller of the Treasury, or their duly appointed representatives.
2. Both parties shall maintain strict confidentiality of patient medical records and other similar records in accordance with the law and established ethical standards.

B. Amendment and Termination:

1. This agreement may be modified only by written amendment executed by both parties hereto and approved by the appropriate bureau officials.
2. This agreement may be terminated by either party by giving written notice to the other at least 30 days before the effective date of such termination. In that event, HSA shall be entitled to receive just and equitable compensation for any satisfactory authorized work completed as of the termination date.
3. If HSA fails to fulfill in timely and proper manner its obligation under this agreement, or if HSA shall violate any of the terms of this agreement, Medicaid shall have the right to immediately terminate this agreement and withhold payments in excess of fair compensation for work completed, and to require HSA to repay to Medicaid any funds expended in contravention of such conditions.

C. Contract Period:

1. This agreement will begin July 1, 1991 and shall extend through June 30, 1992.
2. This agreement shall not be binding upon the parties until it is approved by the Commissioner, Tennessee Department of Health and a copy of said agreement provided to each party.

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

BY: _____
DR. GEORGE SMITH
Director Health Services Administration

BY: _____
MANNY MARTINS
Assistant Commissioner
Medicaid Bureau

BY: _____
H. RUSSELL WHITE
Commissioner
Tennessee Department of Health

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Appendix B: Intradepartmental agreement between the Bureau of Health Services
and
the Bureau of Medicaid

TENNESSEE DEPARTMENT OF HEALTH
INTRADEPARTMENTAL AGREEMENT
BETWEEN
THE BUREAU OF MEDICAID
AND
THE BUREAU OF HEALTH SERVICES
REGARDING DESIGNATION OF TITLE V PROVIDERS
FOR PROVISION OF
CHILDREN'S THERAPEUTIC INTERVENTION SERVICES
THROUGH THE CHILDREN'S PLAN

A. Parties to the Agreement

1. The Bureau of Health Service's is responsible for program planning, policies, and operational management of the Title V program.
2. The Bureau of Medicaid is responsible for policies, planning, and management of the Medicaid program.

B. Scope of Medicaid-covered Services Covered by the Agreement

1. Children's Therapeutic Intervention Services Clinical services and other therapeutic interventions specified in an Individual Care Plan which is based on an assessment of the medical, psychological, social, educational, and other needs of a child and which has been prior approved by a Community Health Agency multidisciplinary assessment team or other entity approved by the Department of Health. Such services include individual, group, or family counseling; parent effectiveness training; behavioral assessment of the child; designing, developing, and monitoring a behavioral management program for a child; one-to-one supervision for therapeutic activities; milieu therapy; supervision related to Individual Care Plan goals and objectives; skill training regarding deficits in activities of daily living related to the child's mental status; skill training of the caregiver in behavioral management; assistance in household management as related to provision of mental health care-related services for the child; and other therapeutic interventions specified by the Individual Care Plan.

Such services must be provided in accordance with an Individual Care Plan and must be provided by, or under the supervision of, an individual having at least a Bachelor's degree from an accredited college or university in nursing, psychology, sociology, social work, or related field. Clinical services must be provided by an appropriately licensed or certified professional in accordance with state law.

C. Persons Eligible to Receive Services Covered by this Agreement

1. In order to be eligible to receive services covered by this agreement, the person must be a child
 - a. who is Medicaid eligible, AND
 - b. who is under the age of 21, AND
 - c. who has an Individual Care Plan which is based on an assessment of the medical, psychological, social, educational, and other needs of the child and which has been prior approved by a Community Health Agency multidisciplinary assessment team or other entity approved by the Department of Health.

D. Designation of Title V providers

1. The Title V Agency (i.e., the Tennessee Department of Health) shall designate Title V providers for the provision of services covered by this agreement to children through the Children's Plan. (See Appendix A for the listing of designated Title V providers.)
2. Such designated Title V providers must
 - a. sign an agreement with the State of Tennessee to provide a specific scope of Medicaid-covered services (i.e., Therapeutic Intervention Services) to children, AND
 - b. provide services to children through the Children's Plan and through the Department of Finance and Administration's provider network for the Children's Plan, AND
 - c. meet applicable state licensure or certification standards, AND
 - d. meet standards established by the Department of Health for the provision of specific Title V services, AND
 - e. comply with federal and state laws, rules, and regulations regarding Title V services and reporting requirements.

E. Timeframe of the Agreement

This agreement is effective July 1, 1991, and shall continue until amended.

Manny Martins
Assistant Commissioner, Bureau of Medicaid

W.L. Moore, M.D.
Assistant Commissioner, Bureau of Health Services

H. Russell White
Commissioner, Department of Health

Appendix C: Interdepartmental Agreement between the Department of Health
and
the Department of Finance and Administration

LETTER OF AGREEMENT
BY AND BETWEEN
THE TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES OFFICE OF MATERNAL AND CHILD HEALTH
AND
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
OFFICE OF CHILDREN'S SERVICES
FOR
THE PROVISIONS OF ADMINISTRATIVE SERVICES FOR TITLE V

This Agreement is made and entered into between the Tennessee Department of Health, Bureau of Health Services, office of Maternal and Child Health hereinafter referred to as TDH and Department of Finance and Administration, Office of Children's Services, hereinafter referred to as FA.

Whereas, the Tennessee Department of Health is the grantee of the Maternal and Child Block Grant and is the single Title V Agency for the administration of maternal and child health services in accordance with the requirements of Title V of the Social Security Act, which it carries out through the Office of Maternal and Child Health; and

Whereas, the Tennessee Department of Finance and Administration provides administrative activities that support the requirements of Title V of the Social Security Act, and are consistent with state and federal policies concerning the administration of maternal and child health services in the state of Tennessee; and

Whereas, TDH and FA mutually recognize that assisting children served by the Office of Maternal and Child Health in assessing their needs will help them to attain or maintain a favorable standard of living which may be beneficial to the general administration of the Maternal and Child Health program in Tennessee; and

Whereas, FA and TDH mutually recognize that coordination between them will serve the best interest of the State of Tennessee;

Now, THEREFORE, in consideration of the mutual promises contained herein the parties have agreed and do hereby enter into this agreement according to the provisions set out herein:

I. Scope of Services

A. TDH shall authorize and designate FA to assist in the administration of the state maternal and child health program authorized under Title V of the Social security Act. FA shall assist by providing administrative activities for Title V eligible children that

(1) meet the definition included in Attachment A, hereinafter made part of this Agreement; and

(2) are performed for children and adolescents served by the Office of Maternal and Child Health under the provisions of the state's comprehensive maternal and child health program.

B. TDH agrees that the following are its responsibilities and obligations under this agreement:

(1) TDH will amend its comprehensive maternal and child health program and its interagency agreement with the Title XIX agency as a result of this agreement; and

(2) TDH will include the administrative activities of FA in the Title V expenditures; and

(3) TDH will assist in the training of the staff of FA in order to provide for compliance with State and Federal laws and regulations.

C. FA agrees that the following are its responsibilities and obligations under this agreement:

(1) FA will provide administrative activities identified in Attachment A; and

(2) For providing said administrative support to the state maternal and child health program, FA shall allocate the portion of their administrative costs dedicated to these activities to Title V and shall apply to TOH for allowable state and federal support of these activities; and

(3) FA shall document this allocation to Title V on the basis described in OKE circular A-87 and Medicaid reimbursement principles; and

(4) FA will ensure that an appropriate audit trail exists; .and

(5) FA shall file such reports and submit such claims in such form and with such frequency as TDH shall require.

(6) FA shall monitor all provider contracts and agreements established to provide service to Title V eligible children.

Appendix D: Presumptive Eligibility Provider Agreement

Presumptive Eligibility Provider Agreement

This agreement is entered into between The Tennessee Department of Health and Environment, Bureau of Medicaid and _____.

Whereas, the Tennessee Department of Health and Environment is the "Single State Agency" designated by the Medical Assistance Act of 1968 and Tennessee Code Annotated Sections 71-5-101, as the State department responsible for the administration of Title XIX of the federal Social Security Act, better known as the Medicaid program; and

Whereas _____, hereinafter referred to as the "qualified Provider", meets the requirements for being a qualified provider to determine presumptive eligibility for pregnant women as defined in Section 1920 (b) (2) of the Social Security Act; and

Whereas, the Department of Health and Environment, Bureau hereinafter referred to as the Bureau of Medicaid, has determined to be capable of making presumptive determinations as described in Section 1920 of the Social Security

Now THEREFORE, the parties agree to the following:

A. THE BUREAU OF MEDICAID AGREES TO:

- (1) Provide the qualified provider with such forms as are necessary for a pregnant woman to make application for medical assistance under the State Medicaid plan; and
- (2) Provide the qualified provider with information on how to assist such women in completing and filing such forms; and
- (3) Provide the qualified provider with guidelines to follow when making the presumptive determination of eligibility based on family income.

B. THE QUALIFIED PROVIDER AGREES TO:

- (1) Notify the Bureau of Medicaid and the Department of Human Services of the determination within 5 working days after the date on which the presumptive eligibility determination (approval) is made; and
- (2) Inform the presumptively eligible pregnant woman at the time the determination is made that she is required to make application for Medicaid at the local Department of Human Services office within 14 calendar days after the date on which the presumptive eligibility determination is made; and
- (3) Inform the pregnant woman who does not appear to be presumptively eligible of her right to file an application at her local Human Services Office if she wishes to have a formal determination made.

This Agreement shall begin on _____ and shall automatically be renewed for successive periods of one year, unless terminated by either party.

Termination of this agreement by either party requires giving written notice to the other party at least (30) thirty days prior to the effective date of such determination.

IN WITNESS, WHEREOF, the parties hereby set their signatures.

Manny Martins Assistant Commissioner Bureau of Medicaid
Assistant Commissioner
Bureau of Medicaid

Signature

FORMPR

APPENDIX E: Title V Providers

- * 95 County Health Departments
- * 10 Regional Health Departments
- * Statewide Family Planning Program
- * Monroe County Maternity Center
- * Maternal and Infant Care Project
- * 12 Community Health Agencies
- * Other Title V providers as designated by the Title V agency.