



**STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
ANDREW JACKSON BUILDING, 15TH FLOOR
500 DEADERICK STREET
NASHVILLE, TN 37243**

TITLE: Provider Application Review Policy

POLICY #: **DRAFT** D - 39

A. PURPOSE: This policy outlines the process for reviewing and approving provider applications from individuals or agencies who seek to become a provider of services through a Medicaid Home and Community-Based Services (HCBS) waiver program.

B. APPLICABILITY: This policy applies to all provider applications from individuals or agencies who seek to become approved as a provider of services through a Medicaid Home and Community-Based Services (HCBS) waiver program. It does not apply to those entities contracted through the Request for Proposal (RFP) process or the Delegated Purchase Authority (DPA) process to provide services other than HCBS waiver services.

C. DEFINITIONS

1. **“DMRS”** means the Division of Mental Retardation Services in the Department of Finance and Administration.
2. **“HCBS waiver”** or **“waiver”** means a Home and Community-Based Services waiver for persons with mental retardation that includes the following;
 - a. Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (#0128.90.R2A.02) and any amendments thereto;
 - b. Home and Community-Based Services Waiver for Persons with Mental Retardation (#0357.90.02) and any amendments thereto; and
 - c. Self-Determination Waiver Program (#0427.R01) and any amendments thereto.
3. **“Provider Agreement”** means a signed agreement between DMRS, the Department of Finance and Administration, the Bureau of TennCare, and an approved provider that specifies the specific waiver services the provider is contracted to provide, the geographic region in which such services may be delivered, the responsibilities of the provider in delivering HCBS waiver services, and the terms and conditions a provider must meet to receive reimbursement for services provided.

D. DESCRIPTION OF POLICY

1. To apply to be a provider of services through a Medicaid Home and Community-Based Services (HCBS) waiver program, the applicant shall complete a Provider Application and

required attachments and shall submit such forms at the same time to the DMRS Central Office Provider Enrollment Coordinator.

2. The provider enrollment packet shall include instructions regarding a provider's right to voluntarily assign payments to the Division of Mental Retardation Services. The provider shall be required to indicate, as part of a complete provider application packet, whether he wishes to have such rights voluntarily assigned.
3. DMRS shall review the completed Provider Application and required attachments within forty-five (45) calendar days of the date of receipt.
 - a. The DMRS Central Office Provider Enrollment Coordinator shall review the completed Provider Application and required attachments to ensure that:
 - (1) All sections of the Provider Application and required attachments have been completed and that the responses meet DMRS requirements;
 - (2) Required professional licenses or certifications are current and active;
 - (3) Required business licenses are current and active or are in the process of being obtained;
 - (4) All required background checks have been completed or are in the process of being obtained; and
 - (5) The applicant meets the provider qualifications as developed and/or approved by TennCare for an HCBS waiver provider.
 - b. The DMRS Central Office Provider Enrollment Coordinator may distribute the applicant's Business Plan Attachment to the applicable DMRS Regional Director or designee for review and recommendation. If so distributed, the Regional Director or designee shall submit the recommendation to the DMRS Central Office Provider Enrollment Coordinator within the forty-five (45) day review period specified above.
4. If the Provider Application and required attachments are incomplete or if the required background checks fail to document that the applicant meets the minimum criteria established by DMRS, the DMRS Central Office Provider Enrollment Coordinator or designee shall notify the applicant by letter.
 - a. Within thirty (30) calendar days, the applicant must provide the required information or clarify any negative findings on the background check or submit a written request for additional time (not to exceed 120 days) to complete or clarify any outstanding issues. If the request for additional time appears to be justified, the DMRS Central Office Provider Enrollment Coordinator or designee shall notify the applicant by letter of the approval of additional time for resolution of outstanding issues.
 - b. If the applicant fails to provide the required information or clarify any negative findings within the 30 day period or, if applicable, any additional time period that was approved, the DMRS Central Office Provider Enrollment Coordinator or designee shall prepare a denial letter for the DMRS Deputy Commissioner's signature. The notice of denial shall specify the reasons for the denial and the process for requesting a review of such decision.
5. After it has been determined that the Provider Application and required attachments are complete (except for pending licenses and certifications) and that DMRS requirements including background checks have been met, the DMRS Central Office Provider Enrollment Coordinator shall notify the applicant that:

- a. The Provider Application and required attachments have been reviewed and that the provider has been determined to meet DMRS provider qualification requirements, contingent upon submission of the following:
 - (1) Documentation to show that all DMRS-required licenses and certifications that were pending, if applicable, have been obtained and are current and active; and
 - (2) A completed and signed DMRS Provider Agreement; and
 - b. The applicant shall not be eligible to bill for services provided through the HCBS waiver program until the applicant has received:
 - (1) A letter of approval from the DMRS Deputy Commissioner or designee specifying the services which the applicant has been approved to provide;
 - (2) A copy of the DMRS Provider Agreement signed by the applicant and all other parties to the agreement; and.
 - (3) A list of approved site codes specifying the locations where the provider has requested to provide waiver services.
6. After receiving the documentation required in Section D.5(a)(1) above and determining that all DMRS provider qualification requirements have been met, the DMRS Central Office Provider Enrollment Coordinator shall process the DMRS Provider Agreement. Once the Provider Agreement has been fully executed by all parties, the DMRS Central Office Provider Enrollment Coordinator shall prepare a letter of approval for the DMRS Deputy Commissioner's signature which specifies the services which the applicant has been approved to provide and which includes a copy of the fully executed DMRS Provider Agreement and a list of approved site codes.
7. Service area expansion requests: Providers who are approved to provide HCBS waiver services in a limited number of counties shall be required to submit a revised Business Plan for review and approval before expansion into other counties, if the provider type is one for which the Provider Application requires submission of a Business Plan Addendum.
- a. The DMRS Central Office Provider Enrollment Coordinator shall review the revised Business Plan Addendum within forty-five (45) calendar days of the date of receipt.
 - b. The DMRS Central Office Provider Enrollment Coordinator may distribute the revised Business Plan Addendum to the applicable DMRS Regional Director or designee for review and recommendation. If so distributed, the Regional Director or designee shall submit the recommendation to the DMRS Central Office Provider Enrollment Coordinator within the forty-five (45) day review period specified above.
 - c. If the revised Business Plan Addendum documents that the provider has the capacity and resources to provide services in the requested service area, the DMRS Central Office Provider Enrollment Coordinator shall notify the applicant that the service area expansion request has been approved.

E. ATTACHMENTS:

- 1. Provider Application (with Business Plan Addendum)

