

CONTRACT #6
RFS # 318.66-026
FA # 02-14632

Finance & Administration
Bureau of TennCare

VENDOR:
Volunteer State Health Plan,
Inc. (TennCare Select)



STATE OF TENNESSEE
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

June 4, 2009

Mr. Jim White, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

RECEIVED

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FISCAL REVIEW

Attention: Ms. Leni Chick

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee, Amendment #20 to Volunteer State Health Plan, Inc., Amendment #22 to Premier Behavioral Health Systems of Tennessee, LLC; and a new contract with Electronic Data Systems, LLC.

Amendment #20 to Volunteer State Health Plan (TennCare Select) is for the continuation for an additional year of medical services currently being provided by the contractor to children in state custody as well as other high risk TennCare enrollees. In addition to extending the contract for an additional year, the amendment also includes language integrating behavioral health services, to begin September 1, 2009, to be provided to the population sectors covered by TennCare Select.

Premier Behavioral Health Systems is the current contractor for the provision of behavioral health services for TennCare Select enrollees. This amendment will extend the term dates of the current contract with Premier for an additional two months to provide transition of behavioral health services to TennCare Select, who will assume the provision of integrated medical and behavioral health services on September 1, 2009. Additionally, the amendment provides funding and payment methodology to support the term extension.

Finally, the Bureau of TennCare is seeking approval to enter into a new contract with Electronic Data Systems (EDS) for the operation and enhancement of the TennCare Management Information Systems (TCMIS), including eight enhancements that will be implemented and operationalized over the next two years and two assessments that will

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evaluate the Bureau's capabilities pertaining to Management and Administrative Reporting and the remediation needs for ICD10 implementation.

The Bureau of TennCare would greatly appreciate the consideration and approval of this contract and amendments by the Fiscal Review Committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Pierce", with a long horizontal flourish extending to the right.

Scott Pierce
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Contract Coordinator

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	615-507-6415		
*Contract Number:	FA-02-14632-00	*RFS Number:	318.66-026		
*Original Contract Begin Date:	July 1, 2001	*Current End Date:	June 30, 2009		
Current Request Amendment Number: <i>(if applicable)</i>		20			
Proposed Amendment Effective Date: <i>(if applicable)</i>		June 30, 2010			
*Department Submitting:		Department of Finance and Administration			
*Division:		Bureau of TennCare			
*Date Submitted:		June 4, 2009			
*Submitted Within Sixty (60) days:		No			
<i>If not, explain:</i>		In the process of identifying a vendor that could provide consistent levels of medical and behavioral health services, the Bureau of TennCare reviewed several options that would provide the same level of medical and behavioral services in an integrated service model. After careful consideration, it was determined that TennCare Select would be the only vendor capable of providing these services for children in state custody and those in high risk. Once the vendor was identified, the development of this model and drafting the appropriate contract language to integrate medical and behavioral health services with the vendor required additional time and review which prevented the Bureau from submitting the contract within 60 days of committee review.			
*Contract Vendor Name:		Volunteer State Health Plan, Inc.			
*Current Maximum Liability:		\$982,177,305.90			
*Current Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Fully Executed Contract Summary Sheet)</i>					
FY: 2002	FY: 2003	FY: 2004	FY: 2005	FY 2006	FY 2007
\$18,599,868	\$33,079,942	\$63,490,156	\$116,014,894	\$175,496,222	\$175,496,222
FY: 2008	FY: 2009				
\$200,000,000	\$200,000,000	\$			
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from STARS or FDAS report)</i>					
FY: 2002	FY: 2003	FY: 2004	FY: 2005	FY 2006	FY 2007
\$290,556,541.35	\$413,769,656.17	\$811,750,972.40	\$990,250.679.53	\$904,108,515.31	\$929,733,206.66
FY: 2008	FY: 2009				
\$367,161,736.62	\$296,041.366.33				
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:			N/A		
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:			N/A		
IF Contract Expenditures exceeded Contract			TennCare is obligated by contract to reimburse the Managed Care		

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Allocation, please give the reasons and explain how funding was acquired to pay the overage:		Organization for medical claims paid by the plan to providers and pay an administrative capitation payment per member to cover administrative costs. The maximum liability amounts for this contract represent the payments made by the state to the plan to provide claims processing and other administrative services for each fiscal year. The contract payments reported for each fiscal year represent both the medical claims reimbursement payments and the administrative payments to the plan.		
*Contract Funding Source/Amount:	State:	\$426,390,720.35	Federal:	\$555,786,585.55
Interdepartmental:			Other:	
If "other" please define:				
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>		Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>		
November 1, 2002		Amendment #1 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase		
May 29, 2003		Amendment #2 - Language Modification, including changes to MCO language; Maximum Liability Increase		
July 1, 2003		Amendment #3 – Language Modification, including changes to MCO language		
November 14, 2003		Amendment #4 - Language Modification, including changes to MCO language; Maximum Liability Increase		
December 15, 2003		Amendment #5 - Language Modification, including changes to MCO language; Maximum Liability Increase		
January 1, 2004		Amendment #6 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase		
July 1, 2004		Amendment #7 – Language Modification, including changes to MCO language		
October 26, 2004		Amendment #8 - Language Modification, including changes to MCO language; Maximum Liability Increase		
January 1, 2005		Amendment #9 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability increase		
May 18, 2005		Amendment #10 - Language Modification, including changes to MCO language; Maximum Liability Increase		
July 1, 2005		Amendment #11 – Language Modification, including changes to MCO language		
January 1, 2006		Amendment #12 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase		
March 30, 2006		Amendment #13 – Language Modification, including changes to MCO language; Maximum Liability Increase		
April 28, 2006		Amendment #14 – Language Modification, including changes to MCO language; Maximum Liability Increase		
July 1, 2006		Amendment #15 – Language Modification, including changes to MCO language; Maximum Liability Increase		
January 1, 2007		Amendment #16 - Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase		
July 1, 2007		Amendment #17 - Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase		
May 1, 2008		Amendment #18 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase		
March 1, 2009		Amendment #19 – This amendment provided Shared Risk for Contractor, payment for Performance Measures, including EPSDT, Medical Service Budget Target, Case Manager Assignment, as well as establish bonus pool for shared risk		

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	<p>initiative. The establishment of partial risk arrangements with managed care entities allows the state to claim a more favorable federal matching rate as well as properly align incentives between the State and the managed care entity.</p>
Method of Original Award: <i>(if applicable)</i> Non Competitive	

Pursuant to the request from the Fiscal Review Committee regarding additional information relative to Volunteer State Health Plan (TennCare Select) amendment #20, the following responses are submitted for consideration.

- (1) **A detailed breakdown of the actual expenditures anticipated in each year of the contract, including specific line items, the source of funds (federal, state, or other--if other, please specify source), and the disposition of any excess funds.**

Actual expenditures are provided by enrollment rates by category as listed below. This contract is paid at Federal Financial Participation (FFP) rate, which differs from year to year. Fiscal Year 2010 FFP is State: .2586 % Federal: .7414 %

A detailed breakdown of anticipated expenditures and payment mechanisms for each year of the contract is listed below as stated in the contract language.

Section 5-1

- b. Effective January 1, 2003, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.00 per member per month. **Effective July 1, 2006, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.20 per member per month.**
- c. Effective January 1, 2003, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

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Effective July 1, 2006, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.57
100,000 to 199,999 enrollees	\$11.45
200,000 to 299,999 enrollees	\$11.32
300,000 to 399,999 enrollees	\$11.20
400,000 to 499,999 enrollees	\$11.09
500,000 to 599,999 enrollees	\$10.88
600,000 to 699,999 enrollees	\$10.73
700,000 to 799,999 enrollees	\$10.58
800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

- i. The applicable administrative fee shall be determined based upon the total number of enrollees in the month preceding the month in which payment is made to the Contractor as determined by TENNCARE. The administrative fee specified shall be applicable to all enrollees in Group 3, Group 4, Group 5 and Group 6 upon attainment of an enrollment level. For example, if enrollment for the month of February is 250,000 enrollees, the administrative fee payment for the month of March shall be \$11.12 per member per month for each Group 3, Group 4, Group 5 and Group 6 enrollee assigned to the CONTRACTOR during the month of March, adjusted as set forth in subparagraphs 5-1.d through 5-1.j, if applicable.

j. *Pay-for-Performance Quality Incentive*

On July 1, 2007 the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2006 to December 31, 2006, if their HEDIS 2007 HbA1C testing rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS HbA1C testing rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the following table where the CONTRACTOR's 2006 HEDIS HbA1C testing rate represents the baseline.

NCQA Minimum Effect Size Change Requirements:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

In addition, on July 1, 2007, the CONTRACTOR will be eligible for another \$0.03 pmpm applied to member months from the period of July 1, 2006 – December 31, 2006. This additional payment will be made if the CONTRACTOR's 2007 HEDIS Prenatal Care rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS

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Prenatal Care rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the table above where the MCO's 2006 HEDIS Prenatal Care rate represents the baseline.

On December 31, 2007, the CONTRACTOR will be eligible for an additional \$0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for asthma has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1,

2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with asthma as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with asthma in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

In addition, on December 31, 2007, the CONTRACTOR will be eligible for an another \$0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with congestive heart failure as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with congestive heart failure in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

On July 1, 2008, the CONTRACTOR will be eligible for a \$0.03 pmpm payment, applied to member months from the period January 1, 2007 to December 31, 2007, for each of the following 2008 HEDIS or CAHPS measures for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology, where the applicable 2007 HEDIS or CAHPS score serves as the baseline.

- **HbA1C Testing**
- **Controlling High Blood Pressure**
- **Timeliness of Prenatal Care**
- **Postpartum Care**
- **Adolescent Immunizations (combo2)**
- **Childhood Immunizations (combo 2)**
- **Cervical Cancer Screening**

k. **Shared Risk Terms and Conditions**

Effective March 1, 2009, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The shared risk terms shall apply to the following populations as described in Section 4-1.1.a of this Contract: Group 1.A, Group 1.B, and Group 2.

The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits. Additionally, there will be both an upside potential (bonus) as well as downside potential (risk). Bonus and the risk will be based on the following components as described below:

EPSDT, and
Medical Services Budget Target.

(1) **Acuity Adjustment**

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The parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology recommended by the State or its actuarial contractor.

The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population described above. As an integral part of evaluating the

CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population described above. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population described above and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

(2) Mandates / Initiatives

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Contract as they are performed and interpreted as of March 1, 2009. As such, services provided as a result of compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Contract as of March 1, 2009 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

(3) Risk Component

The Shared Risk Model will require that a percent of the administrative fees be placed at risk. The Model will set ten percent (10%) of the administrative fee at risk.

The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
EPSDT Compliance	5.0%
Medical Services Budget Target	5.0%

(a) Increase EPSDT Compliance

The target for the period March 1, 2009 through June 30, 2009 is based on the CONTRACTOR's reported screening rate according to the information contained in the CMS 416 Report for FFY 2007 which is 85%.

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The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Contract.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	Administrative Fee Adjustment
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annually with a 90 day lag

At Risk Portion: 5.0% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

(b) Medical Services Budget Target Initiative

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The estimated IBNR shall be reviewed and adjusted by the State's actuarial contractor prior to final determination of performance. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag

At Risk Portion: 5% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

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(4) Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative described below. The bonus pool will represent a total of ten percent (10%) of the administrative fee for the selected population (Group 1.A, Group 1.B, and Group 2) for the CONTRACTOR as described in Section 5-1 of this Contract. The following Initiatives will be included in the Bonus Pool: EPSDT Compliance and Medical Service Budget Target (MSBT).

The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus (% of Admin Rate for Selected Population)
EPSDT Compliance	5.0%
Medical Service Budget Target	5.0%

Additional Bonus Points

Performance – Percent Exceeding Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%
> 105% and ≤ 110%	60%
> 110% and ≤ 117%	100%

Performance – Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

(5) Risk and Bonus Payout Reconciliation

The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Payouts for the annual evaluation period shall be made by October 31 of the following year.

In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the

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CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.

If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

Administrative Fee Effective September 1, 2009:

Group 1.A, Group 1.B, and Group 2

Category	Effective January 1, 2003
Group 1.A	\$29.00 PMPM
Group 1.B	\$29.00 PMPM
Group 2	\$29.00 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

- (2) **A detailed breakdown in dollars of any savings that the department anticipates will result from this contract, including but not limited to, reduction in positions, reduced equipment costs, travel, or any other item related to the contract.**

The TennCare Select contract provides medical services to thousands of TennCare enrollees across the state. This contract continues to provide these services at the same contracted rates for medical services and administrative costs. In addition, from the period of September 2009 through June 2010, TennCare Select will administer behavioral health services to TennCare Select members. Integrating behavioral health services into the TennCare Select contract is not anticipated to increase costs related to providing behavioral health services for the Select population.

- (3) **A detailed analysis in dollars of the cost of obtaining this service through the proposed contract as compared to other options.**

The TennCare Select network was developed to create a consistent level of service and group of providers to serve this population. At present, there is not another viable option to provide this network as it is currently configured.

2002 TennCare Select Vendor payment

Vendor Number	Vendor Suffix	Amount
V621656610	00	290,556,541.35
	Total	290,556,541.35

2003 TennCare Select Vendor payment

Vendor Invoice	Warrant Number	Voucher	Amount
2002-69	P048785	091102NR2	9,392,524.07
2002-70	P055144	091702NR3	10,661,813.93
2002-71	P062257	092402NR4	7,105,264.99
2002-72	P068524	100102NR6	10,945,659.18
2002-73	P076150	100902NR3	8,681,617.84
2002-74	P083369	101502NR2	11,476,661.77
2002-75	P084274	101602NR2	652,206.19
2002-76	P089684	102202NR3	4,834,204.32
2002-77	P096569	102902NR4	15,849,505.83
2002-78	P102381	110502NR6	8,025,508.48
2002-79	P107483	111202NR5	12,226,470.95
2002-80	P116522	111902NR6	8,003,425.42
2002-81	P122933	112502NR2	10,523,735.41
2002-82	P128685	120302NR2	4,791,802.56
2002-83	P135702	121002NR4	12,182,299.13
2002-84	P145330	121702NR9	7,512,867.50
2002-85	P150215	122002NR1	11,070,533.38
2002-86	P155422	123102NR2	4,648,140.62
2003-01	P160508	010703NR5	10,357,303.58
2003-02	P170401	011403NR7	6,531,613.34
2003-03	P173689	012103NR3	9,669,481.84
2003-04	P179975	012803NR1	9,476,743.07
2003-06	P194464	021103NR5	8,234,543.23
2003-07	P202292	021803NR5	13,122,054.97
2003-08	P209638	022503NR3	8,191,323.02
2003-09	P216181	030403NR4	11,504,541.50
2003-10	P223739	031103NR4	8,245,497.34
2003-11	P232607	031803NR4	12,893,442.05
2003-12	P239494	032503NR6	7,425,841.02
2003-13	P246046	040103NR4	11,164,958.94
2003-14	P252368	040803NR7	7,709,575.34
2003-15	P253893	040903NR2	618,264.59
2003-16	P261104	041503NR6	12,491,593.75
2003-17	P266787	042203NR3	9,102,200.18
2003-18	P274218	042903NR4	10,904,296.01
2003-19	P280017	050603NR6	9,161,558.11
2003-20	P289403	051303NR3	12,467,903.24
2003-21	P295524	052003NR4	8,653,596.32

2003-22	P300931	052703NR4	10,678,761.95
2003-23	P308385	060303NR6	8,974,860.87
2003-24	P315549	061003NR4	12,942,681.44
2003-25	P324615	061703NR4	8,048,696.13
2003-25	P331612	062406NR2	15,661,878.76
2003-5	P186972	020403NR3	10,952,204.01
		Total	413,769,656.17

2004 TennCare Select Vendor payment

Vendor Invoice	Warrant Number	Voucher	Amount
2003-27	P339516	070103NR5	9,571,621.66
2003-28	P345419	070803NR4	12,901,141.70
2003-29	P356122	071503NR2	13,114,403.76
2003-30	P361788	072203NR4	10,612,921.84
2003-31	P367474	072903NR4	10,307,908.12
2003-36	P371129	080503NR9	13,384,066.87
2003-33	P377274	081203NR1	10,345,783.89
2003-34	P385856	081903NR6	11,143,261.05
2003-35	P394644	082793NR1	11,669,284.48
2003-36	P397991	090203NR3	11,586,532.73
2003-37	P404206	090903NR4	13,354,953.90
2003-38	P413180	091603NR6	12,633,269.91
2003-39	P420975	092403NR3	15,055,885.62
2003-40	P426714	093003NR6	15,798,808.77
2003-41	P432250	100703NR7	16,415,573.94
2003-41	P441025	101403NR2	(1,064,145.86)
2003-41-	P441025	101403NR2	1,064,145.86
2003-42	P441025	101403NR2	12,133,450.47
2003-42	P447099	102103NR6	44,179.16
2003-42-	P447099	102103NR6	48,915.83
2003-42--	P447099	102103NR6	(93,094.99)
2003-43	P447099	102103NR6	14,215,623.88
2003-43	P453627	102803NR4	20,944.70
2003-43-	P453627	102803NR4	1,039,913.89
2003-43--	P453627	102803NR4	(1,060,858.59)
2003-44	P453627	102803NR4	17,621,780.18
2003-44	P460688	110403NR4	190,334.85
2003-44-	P460688	110403NR4	1,388,563.91
2003-44--	P460688	110403NR4	(1,578,898.76)
2003-45	P460688	110403NR4	13,707,170.77
2003-45	P468670	111203NR2	187,475.89
2003-45-	P468670	111203NR2	797,122.56
2003-45--	P468670	111203NR2	(984,598.45)
2003-46	P468670	111203NR2	15,809,075.76
2003-47	P475333	111803NR4	13,929,696.52
2003-46	P483097	112503NR4	47,781.35
2003-46-	P483097	112503NR4	680,591.02
2003-46--	P483097	112503NR4	(728,372.37)
2003-47	P483097	112503NR4	39,309.50
2003-47-	P483097	112503NR4	638,481.33
2003-47--	P483097	112503NR4	(677,790.83)

2003-48	P483097	112503NR4	14,974,277.93
2003-48	P487383	120203NR5	22,442.87
2003-48-	P487383	120203NR5	554,454.74
2003-48--	P487383	120203NR5	(576,897.61)
2003-49	P487383	120203NR5	8,306,089.43
2003-49	P494604	120903NR4	16,059.06
2003-49-	P494604	120903NR4	158,530.34
2003-49--	P494604	120903NR4	(174,589.40)
2003-50	P494604	120903NR4	18,352,281.27
2003-50	P504141	121603NR6	37,740.06
2003-50-	P504141	121603NR6	664,415.90
2003-50--	P504141	121603NR6	(702,155.96)
2003-51	P504141	121603NR6	15,726,068.53
2003-51	P510184	122203NR4	86,270.36
2003-51-	P510184	122203NR4	1,144,550.20
2003-51--	P510184	122203NR4	(1,230,820.56)
2003-52	P510184	122203NR4	16,430,966.73
2003-52	P515582	123003NR4	27,506.84
2003-52-	P515582	123003NR4	592,937.23
2003-52--	P515582	123003NR4	(620,444.07)
2003-53	P515582	123003NR4	8,721,987.07
2003-53	P520061	010604NR6	18,625.59
2003-53-	P520061	010604NR6	92,378.82
2003-53--	P520061	010604NR6	(111,004.41)
2004-01	P520061	010604NR6	13,000,161.88
2004-01	P529928	011304NR3	21,753.95
2004-01-	P529928	011304NR3	597,456.99
2004-01--	P529928	011304NR3	(619,210.24)
2004-02	P529928	011304NR3	17,546,494.22
2004-02	P535078	012004NR7	63,928.89
2004-02-	P535078	012004NR7	121,655.31
2004-02--	P535078	012004NR7	(185,584.20)
2004-03	P535078	012004NR7	12,868,081.59
2004-03	P549037	020304NR2	10,921.60
2004-03-	P549037	020304NR2	(1,232,670.30)
2004-03--	P549037	020304NR2	1,221,748.70
2004-04	P549037	020304NR2	31,813.28
2004-04-	P549037	020304NR2	357,666.44
2004-04--	P549037	020304NR2	(389,479.72)
2004-05	P549037	020304NR2	16,260,359.96
2004-05	P556339	021004NR6	26,900.83
2004-05-	P556339	021004NR6	305,930.03
2004-05--	P556339	021004NR6	(332,830.86)
2004-06	P556339	021004NR6	18,970,284.89
2004-04	P541761	012704NR5	4,214,773.78
2004-04-	P541761	012704NR5	15,221,252.76
2004-06	P564496	021704NR7	13,238.83

2004-06-	P564496	021704NR7	142,442.76
2004-06--	P564496	021704NR7	(155,681.59)
2004-07	P564496	021704NR7	17,080,163.52
2004-07	P571198	022404NR5	27,734.97
2004-07-	P571198	022404NR5	264,361.31
2004-07--	P571198	022404NR5	(292,096.28)
2004-08	P571198	022404NR5	19,656,057.63
2004-08	P578797	030204NR4	61,776.64
2004-08-	P578797	030204NR4	198,077.82
2004-08--	P578797	030204NR4	(259,854.46)
2004-09	P578797	030204NR4	17,932,603.38
2004-09	P586386	030904NR5	11,330.72
2004-09-	P586386	030904NR5	191,673.51
2004-09--	P586386	030904NR5	(203,004.23)
2004-10	P586386	030904NR5	19,480,654.91
2004-10	P595341	031604NR4	24,364.27
2004-10-	P595341	031604NR4	213,986.50
2004-10--	P595341	031604NR4	(238,350.77)
2004-11	P595341	031604NR4	16,739,640.17
2004-11	P602609	032304NR2	6,301.60
2004-11-	P602609	032304NR2	247,131.18
2004-11--	P602609	032304NR2	(253,432.78)
2004-12	P602609	032304NR2	18,786,140.00
2004-13	P610025	033004NR5	16,268,602.11
2004-14	P616395	040604NR6	18,831,995.00
2004-15	P624541	041304NR3	19,185,757.42
2004-16	P631569	042004NR4	18,113,523.24
2004-17	P638012	042704NR4	16,946,800.75
2004-18	P645376	050404NR4	19,902,428.14
2004-19	P652258	051104NR3	18,259,754.23
2004-20	P661472	051804NR6	17,738,461.86
2004-20	P668376	052504NR8	(400.00)
2004-21	P668376	052504NR8	16,691,824.67
2004-20	Q001625	052704NR2	400.00
2004-22	Q004096	060104NR3	15,043,406.35
2004-23	Q011105	060804NR4	17,669,270.69
2004-24	Q020959	061504NR5	18,459,311.35
2004-25	Q027081	062204NR2	16,249,722.14
2004-26	Q036035	062904NR4	16,809,558.28
		Total	811,750,972.40

2005 TennCare Select Vendor payment

Vendor Invoice	Warrant Number	Voucher	Amount
2004-27	Q042367	070604NR4	13,805,308.23
2004-28	Q043815	070704NR3	1,101,601.81
2004-29	Q053375	071304NR3	17,536,614.77
2004-30	Q059096	072004NR7	17,140,846.34
2004-31	Q063466	072704NR5	21,768,665.01
2004-32	Q069516	080304NR5	17,137,689.89
2004-33	Q075332	081004NR4	20,267,480.86
2004-34	Q084930	081704NR7	18,850,281.71
2004-35	Q092202	082404NR1	17,899,784.19
2004-36	Q099296	083104NR6	19,478,023.19
2004-37	Q104552	090704NR3	18,189,723.57
2004-38	Q113644	091404NR3	16,131,772.44
2004-39	Q120552	092104NR4	19,026,751.60
2004-40	Q127527	092804NR4	20,018,213.38
2004-41	Q134297	100504NR2	18,684,861.89
2004-42	Q141101	101204NR4	18,865,004.09
2004-43	Q150261	101904NR4	15,540,616.56
2004-44	Q157406	102604NR3	25,601,222.15
2004-45	Q165051	110204NR3	18,651,988.03
2004-46	Q170459	110804NR3	17,706,671.30
2004-47	Q180475	111604NR3	16,498,772.25
2004-47B	Q183568	111804NR1	639,879.31
2004-47	Q186373	112204NR2	19,938,964.52
2004-48B	Q189943	112404NR1	853,051.24
2004-49	Q192986	113004NR4	12,286,193.56
2004-50	Q200656	120704NR3	23,229,410.67
2004-51	Q210927	121404NR5	22,942,631.44
2004-52	Q217109	122204NR2	23,469,595.61
2004-53	Q222329	122804NR3	7,384,351.21
2005-01	Q226563	010405NR3	16,083,818.43
2005-02	Q233515	011105NR3	19,578,867.41
2005-03	Q241962	011805NR4	19,607,510.32
2005-04	Q249534	012505NR4	25,823,785.87
2005-05	Q257430	020105NR1	21,368,292.95
2005-06	Q264106	020805NR3	21,654,011.13
2005-07	Q274350	021505NR5	19,863,749.95
2005-08	Q279857	022205NR6	20,615,380.60
2005-07	Q287730	030105NR2	1,089.22
2005-08	Q287730	030105NR2	(1,089.22)
2005-09	Q287730	030105NR2	22,193,003.63
2005-10	Q295874	030805NR4	21,216,557.65
2005-11	Q306182	031505NR2	21,699,893.04
2005-12	Q313549	032205NR2	18,831,307.75
2005-12	Q319248	032905NR4	17,992,341.46
2005-14	Q326639	040505NR3	19,659,202.06
2005-15	Q333302	041205NR1	18,677,731.22
2005-16	Q343240	041905CO6	19,104,939.58
2005-17	Q349882	042605NR2	26,598,290.01
2005-18	Q358432	050305NR1	20,929,323.29

2005-19	Q365115	051005NR2	21,641,385.00
2005-20	Q374441	051705NR4	20,077,386.14
2005-21	Q381801	052405NR2	20,658,158.17
2005-22	Q388730	053105NR2	18,712,519.87
2005-23	Q395119	060705NR4	18,369,808.05
2005-24	Q405289	061405NR4	20,951,295.23
2005-25	Q412166	062105NR3	19,675,061.20
2005-26	Q419968	062805NR2	19,720,981.74
		Total	990,250,679.53

2006 TennCare Select Vendor payment

Vendor Invoice	Voucher	Amount
2005-30	072605NR5	23,530,975.71
2006-04	012406NR2	21,749,449.95
2006-17	042506NR2	21,369,311.52
2005-49	120605NR2	20,606,440.88
2005-29	071905NR3	20,570,935.54
2005-27	070505NR2	20,221,130.26
2006-11	031406NR3	20,197,818.45
2006-26	062706NR3	19,986,895.01
2005-43	102505NR4	19,691,508.89
2005-33	081605NR4	19,498,944.07
2005-51	122005NR2	19,154,057.50
2005-32	080905NR3	19,095,632.45
2006-12	032106NR1	18,990,278.17
2005-47	112105NR2	18,925,878.75
2005-28	071205NR4	18,881,877.95
2006-06	020706NR3	18,556,398.83
2005-50	121305NR2	18,235,062.26
2005-35	083005NR3	18,196,655.52
2006-05	013106NR4	18,186,584.61
2005-46	111505NR4	18,153,665.40
2006-09	022806NR2	18,121,797.95
2006-19	050906NR4	18,120,001.07
2005-40	100405NR2	18,000,182.53
2005-31	080205NR3	17,928,609.59
2006-24	061306NR3	17,830,061.44
2005-45	110805NR1	17,805,545.42
2005-36	090605NR3	17,630,949.44
2005-44	110105NR1	17,567,158.81
2006-14	040406NR3	17,507,708.45
2005-34	082305NR4	17,383,004.25
2006-20	051606NR5	17,220,456.87
2006-03	011706NR4	17,051,015.51
2005-36	091305NR2	16,999,409.92
2006-08	022106NR5	16,983,748.18
2005-39	092705NR2	16,968,298.94
2006-10	030706NR2	16,953,239.25
2006-13	032806NR1	16,850,998.03
2005-42	101805NR1	16,609,270.69
2006-07	021406NR1	16,525,382.24
2006-21	052306NR3	16,260,689.37
2005-38	092005NR3	16,074,495.63

2006-18	050206NR1	16,042,283.90
2006-15	041106NR3	15,975,611.17
2006-15	041806NR4	15,448,206.81
2006-01	010306NR3	15,306,476.97
2006-25	062006NR2	15,305,684.66
2006-22	053006NR2	15,217,720.36
2006-02	011006NR4	14,563,137.47
2005-52	122705NR5	14,001,360.40
2005-41	101105NR1	13,601,677.80
2005-48	112905NR2	10,676,650.10
2005-45B	100905NR1	1,778,180.37
	Total	904,108,515.31

2007 TennCare Select Vendor payment

Vendor Invoice	Invoice Date	Voucher	Amount
2006-26		070306NR2	0.00
2006-27		070306NR2	16,262,352.83
2006-28		071106NR2	15,644,024.82
2006-29		071806NR1	17,005,130.42
2006-30		072606NR2	24,731,415.08
2006-31		080106NR3	16,996,699.73
2006-32	8/8/2006	080906NR2	17,248,515.67
2006-33	8/15/2006	081606NR3	16,577,975.95
2006-34	8/22/2006	082206NR2	17,614,658.55
2006-35	8/29/2006	083006NR3	18,917,975.73
2006-36	9/5/2006	090506NR4	17,210,552.58
2006-37	9/12/2006	091206NR3	13,301,832.88
2006-38	9/19/2006	091906NR3	20,320,994.67
2006-39	9/26/2006	092606NR3	22,180,915.29
2006-40	10/3/2006	100306NR5	23,463,094.52
2006-41	10/10/2006	101006NR2	17,651,414.72
2006-42		101706NR2	16,052,176.14
2006-43	10/24/2006	102406NR2	21,287,276.20
2006-44	10/31/2006	103106NR2	16,248,943.11
2006-45	11/7/2006	110706NR1	22,366,180.20
2006-46	11/14/2006	111406NR4	24,435,987.79
110306	8/23/2006	110606OT1	918,644.43
2006-47	11/20/2006	112006NR2	22,534,216.51
2006-48	11/28/2006	112806NR4	10,768,460.11
2006-49	12/5/2006	120506NR5	25,263,087.62
2006-50	12/12/2006	121206NR5	22,549,726.25
2006-51	12/19/2006	121906NR3	18,261,656.72
2006-52	12/27/2006	122706NR2	18,819,656.44
2007-01	1/2/2007	010207NR4	12,060,139.25
2007-02	1/9/2007	010907NR4	15,822,481.58
2007-03	1/16/2007	011607NR4	19,138,300.02
2007-04	1/23/2007	012307NR3	23,463,730.71
2007-05	1/30/2007	013007NR1	23,425,253.78
2007-06	2/6/2007	020607NR4	20,550,165.93
2007-07	2/13/2007	021307NR2	21,310,244.65
2007-08	2/20/2007	022007NR3	21,145,908.60
2007-09	2/27/2007	022707NR4	28,205,782.76
2007-10	3/6/2007	030607NR2	25,383,408.26
2007-11	3/12/2007	031307NR4	21,670,981.00
2007-12	3/20/2007	032007NR4	22,471,345.50
2007-13	3/27/2007	032707NR5	22,221,662.46
2007-14	4/3/2007	040307NR1	20,444,321.61
2007-15	4/9/2007	041007NR2	21,498,656.91
2007-16	7/16/2007	041707NR1	13,929,180.68
2007-17	4/24/2007	042407NR3	18,684,036.40
2007-18	4/30/2007	050107NR4	11,658,711.12
2007-19	5/8/2007	050807NR3	12,041,186.08
2007-20	5/14/2007	051507NR1	11,253,604.12
2007-21	5/21/2007	052207NR1	10,302,073.28
2007-22	5/29/2007	052907NR1	8,392,623.79
2007-23	6/4/2007	060507NR2	8,727,679.58
2007-24	6/11/2007	061207NR2	8,078,652.35
2007-25	6/18/2007	061907NR2	6,843,275.21
2007-26	6/26/2007	062607NR3	6,376,236.07
		Total	929,733,206.66

2008 TennCare Select Vendor payment

Vendor Invoice	Invoice Date	Voucher	Amount
TPL ADMIN FY08	3/24/2008	032408OT1	590,773.18
2008-01	7/2/2007	070207NR1	8,874,275.93
RATE ADJUST	7/5/2007	070507NR1	13,787,598.00
2008-02	7/9/2007	071007NR1	5,862,696.71
2008-03	7/17/2007	071707NR3	5,278,216.47
2008-04	7/23/2007	072407NR1	9,237,287.76
2008-05	7/31/2007	073107NR6	8,314,595.68
2008-06	8/6/2007	080607NR2	7,923,631.92
2008-07	8/13/2007	081407NR3	7,063,107.76
2008-08	8/20/2007	082107NR5	6,923,114.68
2008-09	8/28/2007	082807NR6	8,590,631.40
2008-10	9/4/2007	090407NR3	5,649,195.03
2008-11	9/10/2007	091107NR3	5,530,250.23
TPL ADMIN	9/14/2007	091407OT1	1,714,667.19
2008-12	9/17/2007	091807NR4	7,186,374.44
2008-13	9/25/2007	092507NR4	7,030,873.28
2008-14	10/2/2007	100207NR2	5,934,061.15
2008-15	10/8/2007	100907NR4	7,013,158.67
NCQA	10/2/2007	100507OT1	134,407.00
2008-16	10/15/2007	101607NR3	6,353,278.06
2008-17	10/22/2007	102307NR5	9,752,014.63
2008-18	10/29/2007	103007NR2	6,301,810.58
2008-19	11/5/2007	110607NR5	7,064,685.71
2008-20	11/13/2007	111307NR6	8,087,177.98
2008-21	11/19/2007	111907NR4	7,034,463.56
2008-22	11/26/2007	112607NR2	4,595,460.36
2008-23	12/4/2007	120407NR5	9,398,864.85
2008-24	12/10/2007	121107NR4	7,183,459.36
2008-25	12/17/2007	121807NR3	7,665,163.71
2008-26	12/26/2007	122607NR3	6,970,653.72
2008-27	1/2/2008	010208NR5	3,815,524.43
2008-28	1/7/2008	010807NR4	3,993,418.36
2008-29	1/14/2008	011508NR3	7,495,270.98
2008-30	1/22/2008	012208NR4	8,933,348.49
2008-31	1/28/2008	012908NR4	6,605,308.64
2008-32	2/5/2008	020508NR3	6,030,307.08
2008-33	2/11/2008	021208NR4	5,571,950.15
2008-34	2/19/2008	021908NR5	5,844,930.94
2008-35	2/25/2008	022608NR4	6,953,700.04
2008-36	3/3/2008	030408NR5	6,105,078.86
2008-37	3/11/2008	031108NR3	7,201,578.61
2008-38	3/17/2008	031808NR4	6,852,789.47
2008-39	3/24/2008	032508NR4	6,816,851.20
2008-40	3/31/2008	040108NR5	6,481,683.64
2008-41	4/8/2008	040808NR3	6,004,251.78
2008-42	4/15/2008	041508NR5	6,900,640.94

2008-43	4/22/2008	042208NR4	9,390,994.69
2008-44	4/29/2008	042908NR4	5,349,680.76
2008-45	5/5/2008	050608NR3	6,731,103.10
2008-46	5/13/2008	051308NR2	6,227,000.38
2008-47	5/20/2008	052008NR3	6,526,640.19
2008-48	5/27/2008	052708NR4	6,904,841.81
2008-49	6/3/2008	060308NR5	4,813,399.62
2008-50	6/10/2008	061008NR4	5,277,854.26
2008-51	6/17/2008	061708NR4	5,188,273.42
2008-52	6/23/2008	062408NR4	6,099,365.78
		Total	367,161,736.62

2009 TennCare Select Vendor Payment

Vendor Invoice	Invoice Date	Voucher	
TPL Q3 FY 08	7/16/2008	071608OT1	390,607.57
TPL QTR 4 FY08	8/14/2008	081408OT2	296,949.69
VSHP200812	12/31/2008	022509CO2	28,697.00
ADMIN PYMT	2/26/2009	032309OT1	3,743,113.24
VSHP200901	1/31/2009	032609CO1	29,442.08
RA100297726	7/1/2008	100297726	477,013.77
RA100297728	7/1/2008	100297728	1,542,229.48
TPL Q3 FY 08	7/16/2008	071608OT2	334,113.75
TPL QTR 4 FY08	8/14/2008	081408OT1	147,383.65
RA100356632	9/2/2008	100356632	468,741.96
RA100356633	9/2/2008	100356633	1,565,625.31
RA100383426	9/30/2008	100383426	483,359.43
RA100383427	9/30/2008	100383427	1,562,143.69
RA100417534	11/4/2008	100417534	335,121.77
RA100417535	11/4/2008	100417535	1,567,488.89
RA100444525	12/2/2008	100444525	304,791.72
RA100444526	12/2/2008	100444526	1,571,396.22
RA100471378	12/29/2008	100471378	130,410.72
RA100471379	12/29/2008	100471379	1,531,752.01
RA100505483	2/3/2009	100505483	135,272.85
RA100505484	2/3/2009	100505484	1,523,025.31
RA100533140	3/3/2009	100533140	135,975.69
RA100533141	3/3/2009	100533141	1,498,094.29
RA100561123	3/31/2009	100561123	133,947.68
RA100561124	3/31/2009	100561124	1,514,079.98
RA100323082	7/29/2008	100323082	480,909.58
RA100323083	7/29/2008	100323083	1,536,319.23
2009-01	7/1/2008	070108NR6	5,986,282.95
2009-02	7/8/2008	070808NR3	4,800,054.49
2009-03	7/15/2008	071508NR4	6,566,145.02
2009-04	7/22/2008	072208NR3	9,821,585.86
2009-05	7/29/2008	072908NR5	8,610,756.69
2009-06	8/5/2008	080508NR4	6,121,801.15
2009-07	8/12/2008	081208NR5	6,328,280.50
2009-08	8/19/2008	081908NR5	5,318,991.16
2009-09	8/26/2008	082608NR5	7,835,975.09
2009-10	9/2/2008	090208NR3	5,618,636.59
2009-11	9/9/2008	090908NR5	8,130,376.17
2009-12	9/16/2008	091608NR4	5,880,753.84
2009-13	9/23/2008	092308NR5	6,958,441.00
2009-14		093008NR2	4,592,655.88
2009-15	10/7/2008	100708NR1	6,051,519.59
2009-16	10/14/2008	101408NR2	6,013,149.83
2009-17	10/21/2008	102108NR5	6,849,471.53
2009-18	10/28/2008	102808NR2	7,836,283.21
2009-19	11/4/2008	110408NR3	5,891,777.12
2009-20	11/12/2008	111208NR2	6,743,829.22

2009-21	11/18/2008	111808NR4	5,577,857.68
2009-22	11/24/2008	112408NR2	5,756,420.98
2009-23	12/2/2008	120208NR1	4,166,410.39
2009-24	12/9/2008	120908NR4	8,059,739.71
2009-25	12/16/2008	121608NR2	6,827,111.51
2009-26	12/22/2008	122208NR2	6,085,475.35
2009-27	12/29/2008	122908NR2	3,495,799.07
2009-28	1/6/2009	010609NR2	4,698,031.72
2009-29	1/13/2009	011309NR5	7,959,522.69
2009-30	1/20/2009	012009NR5	8,349,147.23
2009-31	1/27/2009	012709NR2	9,999,136.43
2009-32	2/3/2009	020309NR2	7,377,347.18
2009-33	2/10/2009	021009NR3	6,611,999.63
2009-34	2/17/2009	021709NR4	6,091,241.78
2009-35	2/24/2009	022409NR5	5,826,233.29
2009-36	3/3/2009	030309NR5	6,133,426.43
2009-37	3/10/2009	031009NR4	8,183,872.04
2009-38	3/17/2009	031709NR2	6,593,399.97
2009-39	3/24/2009	032409NR4	7,813,842.97
2009-40	3/31/2009	033109NR6	8,333,843.37
2009-41	4/7/2009	040709NR3	6,823,896.66
Total			296,041,366.33

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED

Commissioner of Finance & Administration

Date:

Each of the request items below indicates specific information that **must** be individually detailed or addressed **as required**.
A REQUEST CAN NOT BE CONSIDERED IF INFORMATION PROVIDED IS INCOMPLETE, NON-RESPONSIVE, OR DOES NOT CLEARLY ADDRESS EACH OF THE REQUIREMENTS INDIVIDUALLY AS REQUIRED.

RFS #	318.66-026		
STATE AGENCY NAME :	Department of Finance and Administration, Bureau of TennCare		
SERVICE CAPTION :	Provides TennCare covered services to children in State custody and provides a safety net should other MCO's fail.		
CONTRACT #	FA-02-14632-00	PROPOSED AMENDMENT #	20
CONTRACTOR :	Volunteer State Health Plan, Inc.		
CONTRACT START DATE :	July 1, 2001		
CURRENT, LATEST POSSIBLE END DATE : (including ALL options to extend)	06/30/2009		
CURRENT MAXIMUM LIABILITY :	\$982,177,305.90		
LATEST POSSIBLE END DATE WITH PROPOSED AMENDMENT : (including ALL options to extend)	06/30/2010		
TOTAL MAXIMUM COST WITH PROPOSED AMENDMENT : (including ALL options to extend)	\$1,365,307,305.90		
APPROVAL CRITERIA : (select one)	<input checked="" type="checkbox"/> use of Non-Competitive Negotiation is in the best interest of the state		
	<input type="checkbox"/> only one uniquely qualified service provider able to provide the service		
ADDITIONAL REQUIRED REQUEST DETAILS BELOW (address each item immediately following the requirement text)			
(1) description of the proposed additional service and amendment effects :			
This amendment provides the term extension for additional year for medical services that TennCare Select currently provides as well as includes language integrating behavioral services to begin September 1, 2009.			
(2) explanation of need for the proposed amendment :			

RECEIVED

JUN 08 2009

FISCAL REVIEW

This contractor is the managed care organization that provides TennCare covered services to children in state custody as well as other high risk enrollees and provides a safety net should other MCOs fail. In order to provide coverage to these population sections, it is imperative that TennCare continue this contractual association with VSHP (TennCare Select) for medical services as well as the addition of behavioral health services integration.

(3) name and address of the proposed contractor's principal owner(s) :
(not required if proposed contractor is a state education institution)

BlueCross BlueShield 801 Pine St Chattanooga, TN 37402

(4) documentation of OIR endorsement of the Non-Competitive procurement request :
(required only if the subject service involves information technology)

select one:



Documentation Not Applicable to this Request



Documentation Attached to this Request

(5) documentation of Department of Personnel endorsement of the Non-Competitive procurement request :
(required only if the subject service involves training for state employees)

select one:



Documentation Not Applicable to this Request



Documentation Attached to this Request

(6) description of procuring agency efforts to identify reasonable, competitive, procurement alternatives rather than to use non-competitive negotiation :

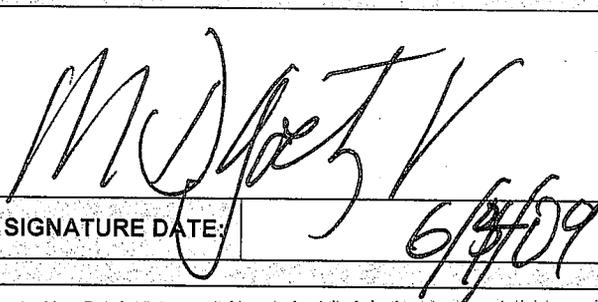
This Contractor is currently providing a network of services for the TennCare Program. This is an amendment to the current contract to extend these services and add behavioral services.

(7) justification of why the F&A Commissioner should approve a Non-Competitive Amendment :

The Bureau of TennCare is amending this contract to continue the services provided to those children in state custody as well as other high risk enrollees, and the provision of a safety net should other MCOs fail. Due to integration of these managed care services, the behavioral health contracts are ending. In order to provide coverage to the the population sections covered by TennCare Select, it is imperative that the state continue this contractual association with VSHP (TennCare Select). TennCare would greatly appreciate approval by the Commissioner of Finance and Administration.

AGENCY HEAD REQUEST SIGNATURE:

(must be signed by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR — signature by an authorized signatory will be accepted only in documented exigent circumstances)



SIGNATURE DATE: 6/3/09

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-20
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V-	<input type="checkbox"/> C-

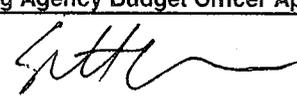
Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date	Contract End Date
7/1/2001	6/30/2010

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$99,077,418.00	\$284,052,582.00			\$383,130,000.00	
Total:	\$ 525,468,138.35	\$ 839,839,167.55			\$1,365,307,305.90	

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs. Check the box ONLY if the answer is YES:

State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Scott Pierce	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	Nashville, TN (615)507-6415	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Scott Pierce		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:	6/30/2009	6/30/2010		
FY: 2002	\$ 18,599,868.48			
FY: 2003	\$ 33,079,942.80			
FY: 2004	\$ 63,490,156.62			
FY: 2005	\$116,014,894.00			
FY: 2006	\$175,496,222.00			
FY: 2007	\$175,151,878.00			
FY: 2008	\$200,000,000.00			
FY: 2009	\$200,000,000.00			
FY: 2010		\$383,130,000.00		
Total:	\$982,177,305.90	\$383,130,000.00		

AMENDMENT NUMBER 20

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

Item 13 shall become effective July 1, 2009. All other Items described below shall become effective September 1, 2009 unless otherwise specified.

- 1. The Section/Sub-section numbering format shall be amended by deleting and replacing dashes (-) with periods (.) and changing the lettering in subsections to numbering so that the Section/Sub-section formatting shall be "1.1.1.1", etc.**
- 2. References to medical services as covered services under this contract shall be amended by adding a reference to "behavioral health" services where appropriate to indicate the full scope of services covered by this contract.**
- 3. Section 1, Definitions, shall be amended by deleting the definition "Behavioral Health Organization (BHO)", adding the following new definitions and deleting and replacing the following existing definitions:**

Administrative Cost - All costs to the Contractor related to the administration of this Agreement that are non-medical in nature, including, but not limited to:

- Satisfying Contractor Qualifications specified in Sections 2.1 and 2.2
- Enrollment and Disenrollment in accordance with Section 2.4 and 2.5;
- Additional services and use of incentives in Section 2.6.7;
- Management of Medical Care and Coordination of Care policies and procedures established in accordance with Section 2.9 with the exception of Medical Case Management;
- Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2.11, Attachment III, Attachment IV, and Attachment V;
- Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2.14;
- Quality Assurance and Improvement activities as specified in Section 2.15;
- Quality Monitoring/Quality Improvement Program established in accordance with Section 2.15;
- Production and distribution of Marketing and Enrollee Materials as specified in Section 2.17;
- Customer service requirements in Section 2.18;
- Appeals processing and resolution in accordance with Section 2.19;
- Determination of recoveries from Third Party Liability resources in accordance with Section 2.21.4;
- Claims Processing in accordance with 2.22;
- Referral and Exemption Requirements established in accordance with this Agreement;
- Out of Area or Out of Plan Use policies and procedures established in accordance with this Agreement;
- Transplant policies and procedures established in accordance with Section 2.6;

Amendment Number 20 (cont.)

- Prenatal Care policies and procedures established in accordance with this Agreement;
- Maintenance and operation of Information Systems in accordance with Section 2.23;
- Personnel requirements in Section 2.29
- Production and submission of required reports as specified in Section 2.30;
- Administration of this Agreement in accordance with Medical Management Policies and Procedures;
- All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;
- Premium tax, and
- All costs related to third party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost".

Behavioral Health Assessment – Procedures used to diagnose mental health or substance abuse conditions and determine treatment plans.

Behavioral Health Services – Mental health and/or substance abuse services.

Benefits – A schedule of health care services, including behavioral health services, that define the covered services available to TennCare enrollees enrolled in the CONTRACTOR's MCO pursuant to this Agreement.

Behavioral Health Services – Mental health and/or substance abuse services.

Centers of Excellence (COE) for Behavioral Health – COEs that provide a limited range of direct services to children in and at risk for state custody (i.e., not just DCS children/youth). These services are to augment the existing service system. Therefore, COEs for Behavioral Health typically only provide services where there is sufficient complexity in the case to warrant the COE for Behavioral Health resources and/or all other means to provide the service in the TennCare network have been exhausted.

Clinically Related Group 1: Severely and/or Persistently Mentally Ill (SPMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. They are recently severely impaired and the duration of their severe impairment totals six months or longer of the past year.

Clinically Related Group 2: Persons with Severe Mental Illness (SMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months of the past year.

Clinically Related Group 3: Persons who are Formerly Severely Impaired – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired but have been severely impaired in the past and need services to prevent relapse.

Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired and are *either* not formerly severely impaired *or* are formerly severely impaired but do not need services to prevent relapse.

Clinically Related Group 5: Persons who are not in clinically related groups 1-4 as a result of their diagnosis – Persons in this group are 18 years or older diagnosed with DSM-IV-TR (and subsequent revisions) substance use disorders, developmental disorders or V-codes only.

Consumer – An individual who uses a mental health or substance abuse service.

CRG (Clinically Related Group) – Defining and classifying consumers 18 years or older into clinically related groups involves diagnosis, the severity of functional impairment, the duration of severe functional impairment, and the need for services to prevent relapse. Based on these criteria, there are five clinically related groups:

Group 1 - Persons with Severe and Persistent Mental Illness (SPMI)

Group 2 - Persons with Severe Mental Illness (SMI)

Group 3 - Persons who were Formerly Severely Impaired and need services to prevent relapse

Group 4 - Persons with Mild or Moderate Mental Disorder

Group 5 - Persons who are not in Clinically Related Groups 1 – 4 as a result of their diagnosis being substance use disorder, developmental disorder, or V-codes

Days – Calendar days unless otherwise specified.

Emergency Medical Condition - A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Evidence-Based Practice – A clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness; specifically, the evidence-based practices recognized by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS).

Grand Region – A defined geographical region that includes specified counties in which the CONTRACTOR is authorized to enroll and serve TennCare enrollees in exchange for a monthly administrative fee payment. The CONTRACTOR shall serve an entire Grand Region. The following counties constitute the Grand Regions in Tennessee:

East Grand Region – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle Grand Region – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West Grand Region – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

Healthcare Effectiveness Data and Information Set (HEDIS) – The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.

Amendment Number 20 (cont.)

Legally Appointed Representative – Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his/her estate.

Mandatory Outpatient Treatment (MOT) – Process whereby a person who was hospitalized for psychiatric reasons and who requires outpatient treatment can be required by a court to participate in that behavioral health outpatient treatment to prevent deterioration in his/her mental condition.

Medical Expenses (sometimes referred to as “Covered Services”) - Consist of the following:

- a. The cost of providing TennCare Program medical and/or behavioral services to enrollees as identified below and pursuant to the following listed Sections of the Agreement:
 1. 2.6.1 Covered Benefits
 2. 2.9.8 Coordination of Dental Services
 3. 2.6.7 Use of Cost Effective Alternative Services
 4. 2.6.9 Coverage of Sterilization’s, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
 5. 2.6.10 Coverage of Organ and Tissue Transplants
 6. all services related to hospice
 7. capitated payment to licensed health care providers
 8. medical services directed by TENNCARE or an Administrative Law Judge
 9. net impact of reinsurance coverage purchased by the MCO
- b. Preventive Services: In order for preventive services in Section 2.6 (including, but not limited to, health education, medical case management and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR’s enrollees or targeted to meet the enrollee’s individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.
- c. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee’s individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.
- d. Medical Expenses do not include:
 1. 2.10 Services Not Covered;
 2. 2.9.10 Institutional Services and Alternatives to Institutional Services;
 3. Services eligible for reimbursement by Medicare;
 4. The activities described in or required to be conducted in Attachments II, III, IV, V, X, XI, XII, XIII, XV (including, but not limited to, utilization management, utilization review activities) are administrative costs; and
 5. The two percent HMO tax.
- e. Medical expense will be net of any TPL recoveries or subrogation activities..
- f. This definition does not apply to NAIC filings.

Medical Records - All medical and behavioral health histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical and behavioral health documentation in written or electronic format; and analyses of such information.

Primary Care Provider - A primary care physician or other licensed health practitioner practicing in accordance with state law who is responsible for providing preventive and primary health care to patients;; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP may practice in various settings such as local health departments, FQHCs or community mental health agencies (CMHAs) provided that the PCP is willing and able to carry out all PCP responsibilities in accordance with this Agreement.

Amendment Number 20 (cont.)

Priority Enrollee – A TennCare enrollee who has been assessed within the past twelve (12) months as belonging in Clinically Related Groups (CRGs) 1, 2, or 3 if he/she is 18 years old or older, or Target Population Group (TPG) 2 if he/she is under the age of 18 years. This assessment as a Priority enrollee expires twelve (12) months after the assessment as been completed. In order for an individual to remain a Priority enrollee after the twelve (12) month period ends, he/she must be reassessed as continuing to meet the criteria to belong in CRGs 1, 2, or 3 or TPG 2 categories. The reassessment, like the initial assessment, expires after twelve (12) months unless another assessment is done. Also referred to as Priority member once the enrollee is enrolled in the CONTRACTOR's MCO.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

Recovery – A consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite a disability.

Resilience – A dynamic developmental process for children and adolescents that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Routine Care – Non urgent and non-emergency medical or behavioral health care such as screenings, immunizations, or health assessments.

Seriously Emotionally Disturbed (SED) – Seriously Emotionally Disturbed shall mean persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the criteria provided below:

Person under the age of 18; and

Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of DSM-IV-TR (and subsequent revisions) V- codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable mental, behavioral, or emotional disturbance other than above exclusions. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and

The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning (GAF) score of 50 or less in accordance with the DSM-IV-TR (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Severely and/or Persistently Mentally Ill (SPMI) – Severely and/or Persistently Mentally Ill shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the following criteria. These persons will be identified as belonging in one of the Clinically Related Groups that follow the criteria:

Age 18 and over; and

Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV-TR (and subsequent revisions) V-codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness other than above exclusions. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and

Amendment Number 20 (cont.)

The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.

Substance Abuse Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

Target Population Group (TPG) – An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and severity of impairment due to a mental illness. Based on these criteria, there are three target population groups.

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).
2. Target Population Group 3: At Risk of a (SED)
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.
3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

Third Party Liability – Any amount due for all or part of the cost of medical or behavioral health care from a third party.

4. **Existing Sections 2-1 and 2-2 and Section 4 shall be deleted and replaced by new Sections 2.1 through 2.5 as described below. The remaining Sections shall be renumbered accordingly as well as any references thereto.**

2.1 GENERAL REQUIREMENTS

- 2.1.1 The CONTRACTOR shall maintain a standard certificate of authority (COA) from TDCI to operate as an HMO in Tennessee in the service area covered by this Agreement. If the CONTRACTOR subcontracts for the provision of behavioral health services, and that subcontractor accepts risk, TDCI may require that the subcontractor be licensed as a Prepaid Limited Health Service Organization (PLHSO). The CONTRACTOR shall ensure that the CONTRACTOR and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Agreement a valid license, as appropriate, and comply with all applicable licensure requirements.

Amendment Number 20 (cont.)

- 2.1.2 The CONTRACTOR shall comply with all the provisions of this Agreement and any amendments thereto and shall act in good faith in the performance of these provisions. The CONTRACTOR shall respect the legal rights (including rights conferred by the Agreement) of every enrollee, regardless of the enrollee's family status as head of household, dependent, or otherwise. Nothing in this Agreement may be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with provisions of this Agreement may result in the assessment of liquidated damages and/or termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement.
- 2.1.3 The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement including all subcontractors, providers, employees, agents, and anyone acting for or on behalf of the CONTRACTOR.
- 2.1.4 Demonstrate sufficient network capability and a willingness, when so directed by TENNCARE, to accept a reasonable number of enrollees enrolled, or requesting enrollment, in any health plan operating in the same community as the CONTRACTOR, including any plan which fails, is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TENNCARE program.

2.2 Requirements for Children in State Custody

- 2.2.1 The CONTRACTOR shall develop and maintain a Best Practice Network of providers with the appropriate expertise and experience and willingness in the special health care needs of children in state custody.
- 2.2.2 The CONTRACTOR hereby agrees to serve as the designated carve-out MCO for the purpose of meeting the needs of children in state custody and agrees to satisfy all special requirements for the delivery of services to children in state custody. The CONTRACTOR further agrees that at such time that any plan for children in State custody is provided and/or approved by the court, the CONTRACTOR shall administer this Agreement in accordance with the requirements of the court order. In the event that TENNCARE makes a determination that the requirements of the court order differ materially from the requirements specified in this Agreement, TENNCARE and the CONTRACTOR agree to negotiate the required amendments to this Agreement for the purpose of incorporating the requirements of the court order. TENNCARE and the CONTRACTOR recognize and agree that said amendment shall reflect mutually agreed upon additional costs to the CONTRACTOR, if any, related to the requirements of the court order, which must be documented by the CONTRACTOR and approved by TENNCARE, for which TENNCARE will compensate the CONTRACTOR.

2.3 ELIGIBILITY

2.3.1 Overview

TennCare is Tennessee's Medicaid program operating under the authority of a research and demonstration project approved by the federal government pursuant to Section 1115 of the Social Security Act. Eligibility for TennCare is determined by the State in accordance with federal requirements and state law and policy.

2.3.2 Eligibility Categories

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population (TennCare Standard).

2.3.2.1 TennCare Medicaid

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

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2.3.2.2 TennCare Standard

TennCare Standard includes the Standard Spend Down (SSD) population as well as an expanded population of children. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.3 **TennCare Applications**

The CONTRACTOR shall not cause applications for TennCare to be submitted.

2.3.4 **Eligibility Determination and Determination of Cost Sharing**

The State shall have sole responsibility for determining the eligibility of an individual for TennCare. The State shall have sole responsibility for determining the applicability of TennCare cost sharing amounts and for the collection of applicable premiums.

2.3.5 **Eligibility for Enrollment in an MCO**

Except for TennCare enrollees enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and enrollees who are only receiving assistance with Medicare cost sharing, all TennCare enrollees will be enrolled in an MCO, including TennCare Select (see definition in Section 1 of this Agreement).

2.4 **ENROLLMENT**

2.4.1 **General**

TENNCARE is solely responsible for enrollment of TennCare enrollees in an MCO. The TennCare Bureau has identified groups of enrollees who may become members of TennCare Select. TennCare enrollees cannot request to enroll in TennCare Select. Eligibility determination and enrollment of TennCare eligible enrollees in the Contractor's plan shall be the sole responsibility of TENNCARE. For purposes of this Agreement, TENNCARE may define enrollees in specified categories for purposes of payments to the CONTRACTOR and/or enrollee eligibility for specified levels of services and benefits as well as cost share responsibilities.

2.4.2 **Authorized Service Area**

2.4.2.1 Grand Region

Enrollees will be enrolled in MCOs by Grand Region(s) of the state. The specific counties in each Grand Region are listed in Section 1 of this Agreement.

2.4.2.2 CONTRACTOR's Authorized Service Area

In addition to enrollees described in Group 5, the CONTRACTOR is authorized under this Agreement to serve enrollees who reside in the Grand Region(s) specified below:

_X_East Grand Region _X_Middle Grand Region _X_West Grand Region

2.4.3 **Maximum Enrollment**

2.4.3.1 The CONTRACTOR shall maintain sufficient capacity to provide services in accordance with the requirements of this Agreement for up to 300,000 enrollees or the actual number of enrollees enrolled, whichever is greater. This provision is not intended to guarantee enrollment of 300,000 enrollees, nor limit enrollment to 300,000 enrollees. Rather, it is intended to demonstrate the CONTRACTOR's ability and readiness to serve as back-up health plan in the event of a failure of a risk MCO, including any plan which is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the

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demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TENNCARE program.

2.4.4 **Enrollment Criteria for TennCare Select**

2.4.4.1 General

TENNCARE shall enroll the following individuals determined eligible for TennCare and eligible for enrollment in an MCO under the authority of a 1915(b) waiver to be enrolled in TennCare Select.

2.4.4.1.1 *Eligible Groups*

2.4.4.1.1.1 **Group 1.A:** Children who are in DCS custody;

2.4.4.1.1.2 **Group 1.B:** Children who are transitioning out of DCS custody;

2.4.4.1.1.3 **Group 2:** Children under 21 who are SSI eligible;

2.4.4.1.1.4 **Group 3:** Children receiving services in an institution or as part of the State's Home and Community Based Service waiver in order to avoid being institutionalized;

2.4.4.1.1.5 **Group 4:** Enrollees residing out-of-state;

2.4.4.1.1.6 **Group 5:** Enrollees that have not responded to TennCare's attempts to contact and/or enrollees that are in specified Groups/Populations defined and identified by the State and agreed to by both parties; and

2.4.4.1.1.7 **Group 6:** Enrollees residing in areas with insufficient capacity in other TennCare MCOs.

2.4.4.1.2 *Assignment Criteria*

2.4.4.1.2.1 TennCare eligible enrollees in groups 1 through 5 will be enrolled in the CONTRACTOR's plan independent of other TennCare eligible enrollees in the same household.

2.4.4.1.2.2 To the extent possible, TennCare shall enroll all enrollees in Group 6 in the same household in the CONTRACTOR's plan.

2.4.4.1.2.3 Children eligible for TennCare as a result of being eligible for SSI will be assigned to TennCare Select (defined in Section 1 of this Agreement) but may opt-out of TennCare Select and choose another MCO.

2.4.4.1.2.4 TennCare enrollees who are children in the custody of the Department of Children's Services (DCS) will be enrolled in TennCare Select. When these enrollees exit state custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled from TennCare Select. After disenrollment from TennCare Select, if the enrollee has a family member in an MCO (other than TennCare Select) he/she will be enrolled in that MCO. Otherwise, the enrollee will be given the opportunity to select another MCO. If the enrollee does not select another MCO, he/she will be assigned to an MCO (other than TennCare Select) using the default logic in the auto assignment process (see Section 2.4.4. 2 below).

2.4.4.1.2.5 TennCare may allow enrollment of new TennCare enrollees in TennCare Select if there is insufficient capacity in other MCOs.

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2.4.4.1.3 *Assignment Provisions for Children in State Custody*

To decrease the likelihood of recidivism, the enrollment period for children in Group 1.A who are transitioning out of state custody shall be extended by a period to be determined by TENNCARE. Children will be assigned to Group 1.B during this post-custody transition period and shall continue to receive services as specified in Section 3 including access to Best Practice Network providers, unless TENNCARE does not extend the enrollment period for children transitioning out of state custody. After the post-custody period of at least the period determined by TENNCARE, children assigned to Group 1.B shall be moved as appropriate, to Groups 2-6 and shall remain a member of the new group until the following change period, or until the child loses eligibility for TennCare. At the option of the State, children deemed to be at "prolonged" risk of state custody may remain in Group 1.B or an on-going basis.

2.4.4.2 Auto Assignment

2.4.4.2.1 TENNCARE will auto assign an enrollee to an MCO, in specified circumstances, including but not limited to, the enrollee does not request enrollment in a specified MCO, cannot be enrolled in the requested MCO, or is an adult eligible as a result of receiving SSI benefits.

2.4.4.2.2 The current auto assignment process does not apply to children eligible for TennCare as a result of being eligible for SSI or children in the state's custody.

2.4.4.2.3 There are four different levels to the current auto assignment process:

2.4.4.2.3.1 If the enrollee was previously enrolled with an MCO and lost TennCare eligibility for a period of two (2) months or less, the enrollee will be re-enrolled with that MCO.

2.4.4.2.3.2 If the enrollee has family members in an MCO (other than TennCare Select), the enrollee will be enrolled in that MCO.

2.4.4.2.3.3 If the enrollee is a newborn, the enrollee will be assigned to his/her mother's MCO.

2.4.4.2.3.4 If none of the above applies, the enrollee will be assigned using default logic that randomly assigns enrollees to MCOs (other than TennCare Select).

2.4.4.2.4 TENNCARE may modify the auto assignment algorithm to change or add criteria including but not limited to quality measures or cost or utilization management performance.

2.4.4.3 Immediate Eligibility for Children in State Custody

Until a final determination can be made on their TennCare eligibility, the CONTRACTOR shall accept notification from DCS that a child has entered state custody and adhere to the following requirements to insure that eligibility is provided. Upon receipt of notification from DCS, the CONTRACTOR shall determine whether or not the child is otherwise enrolled in TennCare. If the child is not currently enrolled, the CONTRACTOR shall immediately build a forty-five (45) day TennCare eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody, or group 1.A enrollee.

2.4.4.3.1 The CONTRACTOR shall generate a letter that will explain that the child has been given forty-five (45) days of coverage from their custody date, pending a final eligibility determination.

2.4.4.3.2 The CONTRACTOR is not required to assign a child for whom immediate eligibility has been established to a BPN PCP until TennCare eligibility is confirmed.

2.4.4.3.3 The CONTRACTOR shall fax the BPN enrollment form and a letter of notification to the DCS Case Manager.

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2.4.4.3.4 The CONTRACTOR's BPN staff shall work with DCS to obtain an EPSDT visit with a BPN provider within twenty-one (21) days of request but no later than thirty (30) days of enrollment.

2.4.4.3.5 After twenty-five (25) days of immediate eligibility coverage, the CONTRACTOR shall identify children whose immediate eligibility will end in twenty (20) days to the DCS Program Coordinator of Health Advocacy.

2.4.4.3.6 The child shall be eligible for the TennCare Medicaid benefit package effective on the date the child was placed in custody through the 45th day of the Immediate Eligibility period or the date of receipt of a TennCare eligibility record, whichever occurs earlier. If the CONTRACTOR receives a TennCare eligibility record prior to the end of the forty-five (45) day eligibility period, the child shall be eligible for benefits in accordance with their TennCare eligibility status effective on the date of receipt of the eligibility record.

2.4.4.4 Non-Discrimination

2.4.4.4.1 The CONTRACTOR shall accept enrollees in the order in which applications are approved and enrollees are assigned to the CONTRACTOR (whether by selection or assignment).

2.4.4.4.2 The CONTRACTOR shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status or need for health care services.

2.4.4.5 Family Unit

If an individual is determined eligible for TennCare and has another family member already enrolled in an MCO, that individual shall be enrolled in the same MCO. This does not apply when the individual or family member is assigned to TennCare Select. If the newly enrolled family member opts to change MCOs during the 45-day change period (see Section 2.4.7.2.1), all family members in the case will be transferred to the new MCO.

2.4.5 **Effective Date of Enrollment**

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

The effective date of initial enrollment in an MCO for TennCare enrollees who are enrolled in accordance with Section 2.4.4.2 shall be the date provided on the enrollment file from TENNCARE. In general, the effective date of enrollment for these enrollees will be the start date of operations.

2.4.5.2 Ongoing Enrollment

In general, a member's effective date of enrollment in the CONTRACTOR's MCO will be the member's effective date of eligibility for TennCare. For SSI enrollees the effective date of eligibility/enrollment is determined by the Social Security Administration in approving SSI coverage for the individual. The effective date of eligibility for other TennCare enrollees is the date of application or the date of the qualifying event (e.g., the date the spend down obligation is met for medically needy enrollees). The effective date on the enrollment file provided by TENNCARE to the CONTRACTOR shall govern regardless of the other provisions of this Section 2.4.5.2.

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE or DCS to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations.

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2.4.5.4 Enrollment Prior to Notification

2.4.5.4.1 Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility or start date of operations, whichever is sooner, the effective date of enrollment may occur prior to the CONTRACTOR being notified of the person's enrollment. Therefore, enrollment of individuals in the CONTRACTOR's MCO may occur without prior notice to the CONTRACTOR or enrollee.

2.4.5.4.2 The CONTRACTOR shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but shall be responsible for the costs of covered services obtained on or after 12:01 a.m. on the effective date of enrollment/eligibility.

2.4.5.4.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility.

2.4.5.4.4 Except for applicable TennCare cost sharing, the CONTRACTOR shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the CONTRACTOR.

2.4.6 **Eligibility and Enrollment Data**

2.4.6.1 The CONTRACTOR shall receive, process, and update enrollment files from TENNCARE, The CONTRACTOR shall also receive, process, and update enrollment files from DCS for children in state custody who are to be given immediate eligibility for a forty-five (45) day period. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE.

2.4.6.2 The CONTRACTOR agrees to accept daily eligibility updates in the form and format specified by TennCare for the purpose of identifying children in state custody and children transitioning out of state custody. Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR agrees to accept and process any adhoc report mutually agreed upon by the CONTRACTOR and TennCare to facilitate timely identification of children in state custody or children transitioning out of state custody.

2.4.6.3 The CONTRACTOR shall provide an electronic eligibility file to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section 2.23.5.

2.4.7 **Enrollment Period**

2.4.7.1 General

2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered services provided to enrollees during their period of enrollment with the CONTRACTOR.

2.4.7.1.2 Enrollment shall begin at 12:01 a.m. on the effective date of enrollment in the CONTRACTOR's MCO and shall end at 12:00 midnight on the date that the enrollee is disenrolled from the CONTRACTOR's MCO (see Section 2.5).

2.4.7.1.3 Once enrolled in the CONTRACTOR's MCO, the member shall remain enrolled in the CONTRACTOR's MCO until or unless the enrollee is disenrolled pursuant to Section 2.5 of this Agreement.

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2.4.7.2 Changing MCOs

2.4.7.2.1 *45-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), Enrollees selected for enrollment in the CONTRACTOR's plan by the State in Groups 1, 2, 3, 5 and 6 shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCO plans. Enrollees in Group 6 shall only be able to request to change MCO plans during this period to the extent capacity is available in another MCO serving the region.

2.4.7.2.2 *Annual Choice Period*

2.4.7.2.2.1 TENNCARE shall provide an opportunity for members to change MCOs (excluding TennCare Select) every twelve (12) months. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select.

2.4.7.2.2.2 Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

2.4.7.2.2.3 Enrollees who select a new MCO shall have one (1) opportunity anytime during the forty-five (45) day period immediately following the specified enrollment effective date in the newly selected MCO to request to change MCOs.

2.4.7.2.3 *Appeal Based on Hardship Criteria*

As provided in TennCare rules and regulations, members may appeal to TENNCARE to change MCOs based on hardship criteria.

2.4.7.2.4 *Additional Reasons for Disenrollment*

As provided in Section 2.5.2, a member may be disenrolled from the CONTRACTOR's MCO for the reasons specified therein.

2.4.8 **Transfers from Other MCOs**

2.4.8.1 The CONTRACTOR shall accept enrollees (enrolled or pending enrollment) who have been selected by the State for enrollment, from any MCO in the CONTRACTOR's service area as authorized by TENNCARE, or from any failed health plan in the CONTRACTOR's service area including any plan which is terminated in whole or in part, may become insolvent or discontinues service, or who reside in an area in which there is insufficient capacity in risk MCOs to enroll the population. The transfer of membership may occur at any time during the year. No enrollee from another MCO shall be transferred retroactively to the CONTRACTOR except as specified in Section 2.4.9. Except as provided in Section 2.4.9, the CONTRACTOR shall not be responsible for payment of any covered services incurred by enrollees transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

2.4.8.2 Transfers from other MCOs shall be in consideration of the maximum enrollment levels established in Section 2.4.3.

2.4.8.3 To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a Grand Region of the impending failure of one of the MCOs serving the Grand Region; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to accept enrollees from failed MCOs.

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2.4.9 Enrollment of Newborns

This policy is only applicable to Group 6 enrollees.

- 2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.
- 2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.
- 2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:
 - 2.4.9.3.1 Disenroll the newborn from the incorrect MCO;
 - 2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO;
 - 2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and
 - 2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.
- 2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the administrative fee payment to the correct MCO.
- 2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 5.8.2 Should it become necessary for TENNCARE to intervene in such

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cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

2.4.10 Information Requirements Upon Enrollment

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, a provider directory and an identification card.

2.5 DISENROLLMENT FROM AN MCO

2.5.1 General

A member may be disenrolled from the CONTRACTOR's MCO only when authorized by TENNCARE.

2.5.2 Acceptable Reasons for Disenrollment from an MCO

With the exception of enrollees in Group 4, a member may request disenrollment or be disenrolled from the CONTRACTOR's MCO if:

- 2.5.2.1 The member selects another MCO during the forty-five (45) day change period after enrollment with the CONTRACTOR's MCO and is enrolled in another MCO;
- 2.5.2.2 The member selects another MCO during the annual choice period and is enrolled in another MCO;
- 2.5.2.3 An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TENNCARE in favor of the member, and the member is enrolled in another MCO;
- 2.5.2.4 The member is assigned incorrectly to the CONTRACTOR's MCO by TENNCARE and enrolled in another MCO;
- 2.5.2.5 The member moves outside the MCO's service area and is enrolled in another MCO;
- 2.5.2.6 During the appeal process, if TENNCARE determines it is in the best interest of the enrollee and TENNCARE (see Section 2.19.2.9);
- 2.5.2.7 The member loses eligibility for TennCare;
- 2.5.2.8 TENNCARE grants members the right to terminate enrollment pursuant to Section 5.8.1, and the member is enrolled in another MCO;
- 2.5.2.9 TENNCARE may disenroll enrollees that were originally enrolled due to insufficient capacity in other TENNCARE MCOs (Group 6) at any time.
- 2.5.2.10 The CONTRACTOR no longer participates in TennCare; or
- 2.5.2.11 This Agreement expires or is terminated.

2.5.3 Unacceptable Reasons for Disenrollment from an MCO

The CONTRACTOR shall not request disenrollment of an enrollee for any reason. TENNCARE shall not disenroll members for any of the following reasons:

- 2.5.3.1 Adverse changes in the enrollee's health;
- 2.5.3.2 Pre-existing medical or behavioral health conditions;
- 2.5.3.3 High cost medical or behavioral health bills;

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- 2.5.3.4 Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
- 2.5.3.5 Enrollee's utilization of medical or behavioral health services;
- 2.5.3.6 Enrollee's diminished mental capacity; or
- 2.5.3.7 Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

2.5.4 Informing TENNCARE of Potential Ineligibility

Although the CONTRACTOR may not request disenrollment of a member, the CONTRACTOR shall inform TENNCARE promptly when the CONTRACTOR knows or has reason to believe that an enrollee may satisfy any of the conditions for termination from the TennCare program as described in TennCare rules and regulations.

2.5.5 Effective Date of Disenrollment

2.5.5.1 Member Requested Disenrollment

All TENNCARE approved disenrollment requests from enrollees shall be effective on or before the first calendar day of the second month following the month of an enrollee's request to disenroll from an MCO. The effective date shall be indicated on the termination record sent by TENNCARE.

2.5.5.2 Other Disenrollments

The effective date of disenrollments other than at the request of the member shall be determined by TENNCARE and indicated on the termination record.

5. Renumbered Section 2.6.1 and 2.6.2 shall be deleted and replaced in its entirety and shall read as follows:

2.6.1 CONTRACTOR Covered Benefits

- 2.6.1.1 The CONTRACTOR shall cover the physical health and behavioral health services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.6.5 and Attachment I.
- 2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health and behavioral health services. This shall include but not be limited to the following:
 - 2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section 2.18.1) that is used by all members, regardless of whether they are calling about physical health and/or behavioral health services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health services.
 - 2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section 2.6.1 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health and/or behavioral health services, and the CONTRACTOR may either route calls to another entity or

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conduct “warm transfers,” but the CONTRACTOR shall not require an enrollee to call a separate number.

- 2.6.1.2.3 As required in Section 2.9.5, the CONTRACTOR shall ensure continuity and coordination between physical health and behavioral health services and ensure collaboration between physical health and behavioral health providers.
- 2.6.1.2.4 Each of the CONTRACTOR’s disease management programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.
- 2.6.1.2.5 As required in Section 2.9.4.2.2, the CONTRACTOR shall provide MCO case management to members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide MCO case management to enrollees with co-morbid physical health and behavioral health conditions. If a member with co-morbid physical and behavioral health conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member’s MCO case managers collaborate and communicate in an effective and ongoing manner.
- 2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services and behavioral health services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.
- 2.6.1.2.7 The CONTRACTOR’s administrator/project director (see Section 2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities.
- 2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE	BENEFIT LIMIT
Inpatient Hospital Services	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.7).</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, including rehabilitation hospital facility.</p>
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary.

SERVICE	BENEFIT LIMIT
<p>TENNderCare Services</p>	<p>Medicaid/Standard Eligibles, Age 21 and older: Not covered.</p> <p>Medicaid/Standard Eligibles, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.5.</p>
<p>Preventive Care Services</p>	<p>As described in Section 2.7.4.</p>
<p>Lab and X-ray Services</p>	<p>As medically necessary.</p>
<p>Hospice Care</p>	<p>As medically necessary. Shall be provided by a Medicare-certified hospice.</p>
<p>Dental Services</p>	<p>Dental Services shall be provided by the Dental Benefits Manager.</p> <p>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.</p>
<p>Vision Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENNderCare requirements.</p>
<p>Home Health Care</p>	<p>As medically necessary in accordance with <u>Newberry</u>.</p>
<p>Pharmacy Services</p>	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).</p>

SERVICE	BENEFIT LIMIT
Durable Medical Equipment (DME)	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
Medical Supplies	<p>As medically necessary.</p> <p>Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
Emergency Air And Ground Ambulance Transportation	<p>As medically necessary.</p>
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	<p>Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XIV). Non emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XIV) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement).</p> <p>If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort.</p> <p>Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).</p> <p>The CONTRACTOR is not responsible for providing NEMT to any service that is being provided to the member through a HCBS waiver.</p> <p>Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XIV) is not a covered NEMT service.</p> <p>If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2.7.5.4.6).</p> <p>Failure to comply with the provisions of this Section may result in liquidated damages.</p>

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SERVICE	BENEFIT/LIMIT
Renal Dialysis Services	As medically necessary.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Occupational Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.</p>

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SERVICE	BENEFIT LIMIT
Reconstructive Breast Surgery	Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.7).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE	BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary.
24-hour Psychiatric Residential Treatment	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Outpatient Mental Health Services (including physician services)	As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits¹	<p>Medicaid/Standard Eligible, Age 21 and older: Limited to ten (10) days detox, \$30,000 in medically necessary lifetime benefits, unless otherwise described in the 2008 Mental Health Parity Act as determined by TennCare.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Mental Health Case Management	As medically necessary.
Psychiatric-Rehabilitation Services	As medically necessary.
Behavioral Health Crisis Services	As necessary.
Lab and X-ray Services	As medically necessary.

SERVICE	BENEFIT LIMIT
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	Same as for physical health (see Section 2.6.1.3 above).

¹When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2.6.2 TennCare Benefits Provided by TENNCARE

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.3 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TENNCARE. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.3 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TENNCARE. Coverage of pharmacy services is described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 Institutional Services and Alternatives to Institutional Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or alternatives to institutional services provided through the Home and Community Based Services (HCBS) waivers.

6. Existing Sections 2-3.5 “Dental Services”, 2-3.8 “Institutional Services and Alternatives to Institutional Services”, 2-3.9 “Coordination with Medicare”, 2-3.14 “Use of a Drug Formulary”, 2-3.19 “Coordination of MCO and PBM Benefits”, and 2-3.20 “Coordination with Department of Education” shall be deleted in their entirety and the remaining Sections shall be renumbered accordingly, including references thereto. The newly renumbered Section 2.6.5 shall be deleted and replaced in its entirety as follows.

2.6.5 Behavioral Health Services

2.6.5.1 General Provisions

2.6.5.1.1 The CONTRACTOR shall provide all behavioral health services as described in this Section, Section 2.6.5 and Attachment V.

2.6.5.1.2 The CONTRACTOR shall provide behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures issued by TDMHDD and approved by the Bureau of TennCare, including but not limited to “Managed Care Standards for Delivery of Behavioral Health Services”.

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- 2.6.5.1.3 The CONTRACTOR shall ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Providers included in this requirement are:
 - 2.6.5.1.3.1 Community mental health agencies;
 - 2.6.5.1.3.2 Case management agencies;
 - 2.6.5.1.3.3 Psychiatric rehabilitation agencies;
 - 2.6.5.1.3.4 Psychiatric and substance abuse residential treatment facilities; and
 - 2.6.5.1.3.5 Psychiatric and substance abuse inpatient facilities.
- 2.6.5.1.4 Individualized treatment plans shall be completed within thirty (30) calendar days of the start date of service and updated every six (6) months, or more frequently as clinically appropriate. The treatment plans shall be developed; negotiated and agreed upon by the members and/or their support systems in face-to-face encounters and shall be used to identify the treatment needs necessary to meet the members' stated goals. The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.
- 2.6.5.2 Psychiatric Inpatient Hospital Services
 - 2.6.5.2.1 The CONTRACTOR shall ensure that all psychiatric inpatient hospitals serving children, youth, and adults separate members by age and render developmental age appropriate services.
 - 2.6.5.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are accredited by the Joint Commission and accept voluntary and involuntary admissions.
- 2.6.5.3 24-Hour Psychiatric Residential Treatment
 - 2.6.5.3.1 The CONTRACTOR shall ensure that 24-hour psychiatric residential treatment facilities (RTFs) serving children, youth, and adults separate members by age and render developmental age appropriate services.
 - 2.6.5.3.2 The CONTRACTOR shall ensure RTFs have the capacity to render short term crisis stabilization and long-term treatment and rehabilitation.
 - 2.6.5.3.3 The CONTRACTOR shall ensure all RTFs meet local housing codes.
 - 2.6.5.3.4 The CONTRACTOR shall ensure all RTFs are accredited by a State-recognized accreditation organization as required by 42 CFR 441.151.
- 2.6.5.4 Outpatient Mental Health Services
 - 2.6.5.4.1 The CONTRACTOR shall ensure that outpatient mental health providers (including providers of intensive outpatient and providers of partial hospitalization services) serving children, youth and adults separate members by age and render developmental age appropriate services.
 - 2.6.5.4.2 The CONTRACTOR shall ensure outpatient mental health providers are capable of rendering services both on and off site, as appropriate, depending on the services being rendered. On site services include, but are not limited to intensive outpatient services, partial hospitalization and many types of therapy. Off site services include but are not limited to intensive in home service for children and youth and home and community treatment for adults.

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2.6.5.5 Inpatient, Residential & Outpatient Substance Abuse Services

2.6.5.5.1 The CONTRACTOR shall provide substance abuse treatment through inpatient, residential and outpatient services.

2.6.5.5.2 Detoxification services may be rendered as part of inpatient, residential or outpatient services, as clinically appropriate. The CONTRACTOR shall ensure all member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluations by a physician or a registered nurse.

2.6.5.6 Mental Health Case Management

2.6.5.6.1 The CONTRACTOR shall provide mental health case management services only through providers licensed by the State to provide mental health outpatient services.

2.6.5.6.2 The CONTRACTOR shall provide mental health case management services according to mental health case management standards set by the State and outlined in Attachment I. Mental health case management services shall consist of two (2) levels of service as specified in Attachment I.

2.6.5.6.3 The CONTRACTOR shall require its providers to collect and submit individual encounter records for each mental health case management visit, regardless of the method of payment by the CONTRACTOR. The CONTRACTOR shall identify and separately report "level 1" and "level 2" mental health case management encounters outlined in Attachment I.

2.6.5.6.4 The CONTRACTOR shall require mental health case managers to involve the member, the member's family or parent(s), or legally appointed representative, PCP and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.

2.6.5.6.5 The CONTRACTOR shall ensure the continuing provision of mental health case management services to members under the conditions and time frames indicated below:

2.6.5.6.5.1 Members receiving mental health case management services at the start date of operations shall be maintained in mental health case management until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;

2.6.5.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be evaluated for mental health case management services and provided with appropriate behavioral health follow-up services; and

2.6.5.6.5.3 The CONTRACTOR shall review the cases of members referred by PCPs or otherwise identified to the CONTRACTOR as potentially in need of mental health case management services and shall contact and offer such services to all members who meet medical necessity criteria.

2.6.5.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer support, illness management and recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

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2.6.5.8 Behavioral Health Crisis Services

2.6.5.8.1 *Entry into the Behavioral Health Crisis Services System*

2.6.5.8.1.1 The State shall maintain a statewide toll-free telephone number for entry into the behavioral health crisis system. This line shall be for any individual in the general population for the purposes of providing immediate phone intervention by trained crisis specialists and dispatch of mobile crisis teams.

2.6.5.8.1.2 The CONTRACTOR shall ensure that the crisis telephone line is linked to an appropriate crisis service team staffed by qualified crisis service providers in order to provide crisis intervention services to members.

2.6.5.8.1.3 As required in Section 2.11.5.3, the CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by the State.

2.6.5.8.1.4 The CONTRACTOR shall require the crisis service teams to provide telephone and walk-in triage screening services, telephone and face-to-face crisis intervention/assessment services, and follow-up telephone or face-to-face assessments to ensure the safety of the member until the member's treatment begins and/or the crisis is alleviated and/or stabilized.

2.6.5.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that the member has been evaluated by a crisis team. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

2.6.5.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

2.6.5.8.2.1 The CONTRACTOR shall ensure access to behavioral health crisis respite and crisis stabilization services.

2.6.5.8.2.2 Behavioral health crisis respite services provide immediate shelter to members with emotional/behavioral problems who are in need of emergency respite. The CONTRACTOR shall ensure that behavioral health crisis respite services are provided in a CONTRACTOR approved community location.

2.6.5.8.2.3 The CONTRACTOR shall ensure behavioral health crisis stabilization services are rendered at sites licensed by the State. These services are more intensive than regular behavioral health crisis services in that they require more secure environments, highly trained staff, and typically have longer stays.

2.6.5.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE on a quarterly basis as described in Section 2.30.4.4.

2.6.5.9 Clinically Related Group (CRG) and Target Population Group (TPG) Assessments

2.6.5.9.1 The CONTRACTOR shall provide CRG/TPG assessments in response to requests from members or legally appointed representatives or, in the case of minors, the members' parents or legally appointed representatives, behavioral health providers, PCPs, or the State.

2.6.5.9.2 The CONTRACTOR shall complete CRG/TPG assessments within fourteen (14) calendar days of the requests. The CONTRACTOR shall not require prior authorization in order for a member to receive a CRG/TPG assessment.

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- 2.6.5.9.3 The CONTRACTOR shall ensure that its contract providers are trained and that there is sufficient capacity to perform CRG/TPG assessments. The CONTRACTOR shall require providers to use the CRG/TPG assessment form(s) as appropriate, prescribed by and in accordance with the policies of the state. The CRG/TPG assessments shall be subject to review and prior written approval by the State.
- 2.6.5.9.4 The CONTRACTOR shall identify persons in need of CRG/TPG assessments. The CONTRACTOR shall use the CRG/TPG assessments to identify persons who are SPMI or SED for reporting and tracking purposes, in accordance with the definitions contained in Section 1.
- 2.6.5.9.5 The CONTRACTOR shall ensure that providers who perform CRG/TPG assessments have been trained and authorized by the State to perform CRG/TPG assessments. Certified trainers shall be responsible for providing rater training within their agencies.
- 2.6.5.9.6 The CONTRACTOR shall reject all CRG/TPG assessments completed by unapproved raters. The CONTRACTOR shall report on rejected assessments as required in Section 2.30.4.6.
- 2.6.5.9.7 The CONTRACTOR shall conduct audits of CRG/TPG assessments for accuracy and conformity to state policies and procedures. The CONTRACTOR shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits and the results of these audits shall be reported as required in Sections 2.30.4.7 and 2.30.4.8.
- 2.6.5.10 Judicial Services
- 2.6.5.10.1 The CONTRACTOR shall provide covered court ordered behavioral health services to its members pursuant to court order(s). The CONTRACTOR shall furnish these services in the same manner as services furnished to other members.
- 2.6.5.10.2 The CONTRACTOR shall provide for behavioral health services to its members in accordance with state law. Specific laws employed include the following:
 - 2.6.5.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release.
 - 2.6.5.10.2.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (TCA 33-6-708);
 - 2.6.5.10.2.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (TCA 33-6, Part 6);
 - 2.6.5.10.2.4 Inpatient psychiatric examination for up to forty-eight (48) hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (TCA 33-3-607);
 - 2.6.5.10.2.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (TCA 33-6, Part 2); and
 - 2.6.5.10.2.6 Voluntary psychiatric hospitalization for persons with a severe impairment when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA 33-6, Part 3).

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2.6.5.11 Mandatory Outpatient Treatment

2.6.5.11.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a thirty (30) to sixty (60) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).

2.6.5.11.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.6.5.11.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

7. **The newly renumbered Section 2.6.8 shall be deleted and replaced in its entirety.**

2.6.8 Advance Directives

2.6.8.1 The CONTRACTOR shall maintain written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives, including but not limited to 42 CFR 422.128, 438.6 and 489 Subpart I; TCA 32-11-101 *et seq.*, 34-6-201 *et seq.*, and 68-11-201 through 68-11-224; and any requirements as stipulated by the member. Any written information provided by the CONTRACTOR shall reflect changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change.

2.6.8.2 The CONTRACTOR shall provide its policies and procedures to all members eighteen (18) years of age and older and shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members and/or contract providers are responsible for providing this education.

2.6.8.3 The CONTRACTOR shall educate its staff about its policies and procedures on advance directives, situations in which advance directives may be of benefit to members, and their responsibility to educate members about this tool and assist them to make use of it.

2.6.8.4 The CONTRACTOR, for behavioral health services, shall provide its policies and procedures to all members sixteen (16) years of age and older and shall educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment under TCA Title 33, Chapter 6, Part 10. The CONTRACTOR shall specifically designate staff members and/or providers responsible for providing this education.

8. **The newly renumbered Section 2.6.13 shall be deleted and replaced in its entirety and references thereto shall be updated accordingly.**

2.6.13 **TENNderCare**

2.6.13.1 General Provisions

2.6.13.1.1 The CONTRACTOR shall provide TENNderCare services to members under age twenty-one (21) in accordance with TennCare and federal requirements including TennCare rules and regulations, TennCare policies and procedures, 42 USC 1396a(a)(43), 1396d(a) and (r), 42 CFR Part 441, Subpart B, the Omnibus Budget Reconciliation Act of 1989, and the State Medicaid Manual. TENNderCare services means early and periodic screening, diagnosis and treatment of members under age twenty-one (21) to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit as described in Section 2.6.1.

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- 2.6.13.1.2 The CONTRACTOR shall use the name "TENnderCare" in describing or naming the State's EPSDT program or services. This requirement is applicable for all policies, procedures and other material, regardless of the format or media. No other names or labels shall be used.
- 2.6.13.1.3 The CONTRACTOR shall have written policies and procedures for the TENnderCare program that include coordinating services with child-serving agencies and providers, providing all medically necessary TENnderCare services to all eligible members under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, and conducting outreach and education. The CONTRACTOR shall ensure the availability and accessibility of required health care resources and shall help members and their parents or legally appointed representatives use these resources effectively.
- 2.6.13.1.4 The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit).
- 2.6.13.1.5 The CONTRACTOR shall:
 - 2.6.13.1.5.1 Require that providers provide TENnderCare services;
 - 2.6.13.1.5.2 Require that providers make appropriate referrals and document said referrals in the member's medical record;
 - 2.6.13.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TENnderCare services;
 - 2.6.13.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers; and
 - 2.6.13.1.5.5 Monitor provider compliance with required TENnderCare activities including compliance with proper coding.
- 2.6.13.1.6 The CONTRACTOR shall require that its contract providers notify the CONTRACTOR in the event a screening reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability to make an appropriate referral, the CONTRACTOR shall secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation. In the event the failed referral is for dental services, the CONTRACTOR shall coordinate with the DBM to arrange for services.
- 2.6.13.1.7 The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary covered services regardless of whether the need for such services was identified by a provider who had received prior authorization from the CONTRACTOR or from a contract provider.
- 2.6.13.1.8 The CONTRACTOR shall have a tracking system to monitor each TENnderCare eligible member's receipt of the required screening, diagnosis, and treatment services. The tracking system shall have the ability to generate immediate reports on each member's TENnderCare status, reflecting all encounters reported more than sixty (60) days prior to the date of the report.
- 2.6.13.1.9 In the event that a member under sixteen (16) years of age is seeking behavioral health TENnderCare services and the member's parent(s), or legally appointed representative is unable to accompany the member to the examination, the CONTRACTOR shall require that its providers either contact the member's parent(s), or legally appointed representative to discuss the findings and inform the family of any other necessary health care, diagnostic

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services, treatment or other measures recommended for the member or notify the MCO to contact the parent(s), or legally appointed representative with the results.

2.6.13.2 Member Education and Outreach

- 2.6.13.2.1 The CONTRACTOR shall be responsible for outreach activities and for informing members who are under the age of twenty-one (21), or their parent or legally appointed representative, of the availability of TENNderCare services. All TENNderCare member materials shall be submitted to TENNCARE for written approval prior to distribution in accordance with Section 2.17.1 and shall be made available in accordance with the requirements specified in Section 2.17.2.
- 2.6.13.2.2 The CONTRACTOR shall have a minimum of six (6) "outreach contacts" per member per calendar year in which it provides information about TENNderCare to members. The minimum "outreach contacts" include: one (1) member handbook as described in Section 2.17.4, four (4) quarterly member newsletters as described in Section 2.17.5, and one (1) reminder notice issued before a screening is due. The reminder notice shall include an offer of transportation and scheduling assistance.
- 2.6.13.2.2.1 The CONTRACTOR shall conduct New Member Calls for all new members under the age of twenty-one (21) to inform them of TENNderCare services including assistance with appointment scheduling and transportation to appointments.
- 2.6.13.2.2.2 The CONTRACTOR shall have the ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency. At least one of the 6 outreach attempts identified above shall advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.
- 2.6.13.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TENNderCare screens are due.
- 2.6.13.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.
- 2.6.13.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TENNderCare has used no services within a year and shall make two (2) reasonable attempts to re-notify such members about TENNderCare. The attempts must be different in format or message. One (1) of these attempts can be a referral to DOH for a screen.. (These two (2) attempts are in addition to the one (1) attempt per quarter mentioned in Section 2.6.13.2.4 above.)
- 2.6.13.2.6 The CONTRACTOR shall require that providers have a process for documenting services declined by a parent or legally appointed representative or mature competent child, specifying the particular service was declined. This process shall meet all requirements outlined in Section 5320.2.A of the State Medicaid Manual.
- 2.6.13.2.7 The CONTRACTOR shall make and document a minimum of two (2) reasonable attempts to find a member within thirty (30) days of receipt of mail returned as undeliverable. At least one (1) of these attempts shall be by phone.

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- 2.6.13.2.8 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section 2.17.7 of this Agreement.
- 2.6.13.2.9 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TENNderCare services for their children. The CONTRACTOR shall offer TENNderCare services for the child when it is born.
- 2.6.13.2.10 The CONTRACTOR shall provide member education and outreach in community settings. Outreach events shall be conducted in each Grand Region covered by this Agreement, in accordance with the following specifications:
- 2.6.13.2.10.1 Outreach events shall number a minimum of 5 per region per quarter.
- 2.6.13.2.10.2 At least 3 of the minimum quarterly outreach activities must be conducted in urban or suburban areas, and 2 must be conducted in rural areas. Results of the CONTRACTOR's 416 report and HEDIS report, as well as county demographics, must be utilized in determining counties for targeted activities and in developing strategies for TennCare enrollees who are in or at risk of DCS custody or have special healthcare needs.
- 2.6.13.2.10.3 The CONTRACTOR shall contact a minimum of 15 state agencies or community-based organizations per quarter, to either educate them on services available through the MCO or to develop outreach and educational initiatives. All of the agencies engaged must be those who serve TennCare enrollees who are in or at risk of DCS custody or have special healthcare needs.
- 2.6.13.3 Screening
- 2.6.13.3.1 The CONTRACTOR shall provide periodic comprehensive child health assessments meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth."
- 2.6.13.3.2 At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare web site. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.
- 2.6.13.3.3 The screens shall include, but not be limited to:
- 2.6.13.3.3.1 Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
- 2.6.13.3.3.2 Comprehensive unclothed physical examination, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender);
- 2.6.13.3.3.3 Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;

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- 2.6.13.3.3.4 Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;
- 2.6.13.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than ten (10) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and
- 2.6.13.3.3.6 Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members' parents or to the legally appointed representative to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- 2.6.13.3.4 The CONTRACTOR shall encourage providers to refer children to dentists for periodic dental screens beginning no later than three (3) years of age and earlier as needed (as early as six (6) to twelve (12) months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate.
- 2.6.13.3.5 The CONTRACTOR shall establish a procedure for PCPs or other providers completing TENNderCare screenings to refer TENNderCare eligible members requiring behavioral health services to appropriate providers.
- 2.6.13.4 Services
- 2.6.13.4.1 Should screenings indicate a need, the CONTRACTOR shall provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section 2.6.13.4.8). This includes, but is not limited to, the services detailed below.
- 2.6.13.4.2 The CONTRACTOR shall provide treatment for defects in vision and hearing, including eyeglasses and hearing aids.
- 2.6.13.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TENNderCare eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- 2.6.13.4.4 The CONTRACTOR shall not require prior authorization or written PCP referral in order for a member to obtain a mental health or substance abuse assessment, whether the assessment is requested as follow-up to a TENNderCare screening or an interperiodic screening. This requirement shall not preclude the CONTRACTOR from requiring notification for a referral for an assessment. Furthermore, the CONTRACTOR shall establish a procedure for PCPs, or other providers, completing TENNderCare screenings, to refer members under the age of twenty-one (21) for a mental health or substance abuse assessment.
- 2.6.13.4.5 For services not covered by Section 1905(a) of the Social Security Act, but found to be needed as a result of conditions disclosed during screening and diagnosis, the CONTRACTOR shall provide referral assistance as required by 42 CFR 441.61, including referral to providers and State health agencies.

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2.6.13.4.6 Transportation Services

2.6.13.4.6.1 The CONTRACTOR shall provide transportation assistance for a child and for the child's escort or accompanying adult, including related travel expenses, cost of meals, and lodging en route to and from TennCare covered services. The requirement to provide the cost of meals shall not be interpreted to mean that a member (or the child's escort or accompanying adult) can request meals while in transport to and from care. Reimbursement for meals and lodging shall only be provided when transportation for a TennCare covered service cannot be completed in one (1) day and would require an overnight stay.

2.6.13.4.6.2 The CONTRACTOR shall offer transportation and scheduling assistance to all members under age twenty-one (21) who do not have access to transportation in order to access covered services. This may be accomplished through various means of communication to members, including but not limited to, member handbooks, TENNderCare outreach notifications, etc.

2.6.13.4.7 Services for Elevated Blood Lead Levels

2.6.13.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels in accordance with the State Medicaid Manual, Part 5. The Manual currently says that children with blood lead levels equal to or greater than ten (10) ug/dL should be followed according to CDC guidelines. These guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

2.6.13.4.7.2 The CONTRACTOR shall provide for any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary when elevated blood lead levels are identified in children. Such services would include both MCO case management services and a one (1) time investigation to determine the source of lead.

2.6.13.4.7.3 The CONTRACTOR is responsible for the primary environmental lead investigation—commonly called a “lead inspection”—for children when elevated blood levels suggest a need for such an investigation.

2.6.13.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

2.6.13.4.7.5 CONTRACTOR reimbursement for the primary environmental investigations is limited to the items specified in Part 5 of the State Medicaid Manual. These items include the health professional's time and activities during the on-site investigation of the child's primary residence. They do not include testing of environmental substances such as water, paint, or soil.

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2.6.13.4.8 Services Chart

Pursuant to federal and state requirements, TennCare enrollees under the age of 21 are eligible for all services listed in Section 1905(a) of the Social Security Act. These services, and the entity responsible for providing them to TennCare enrollees under the age of 21, are listed below. Notwithstanding any other provision of this Agreement, the CONTRACTOR shall provide all services for which "MCO" is identified as the responsible entity to members under the age of 21. All services, other than TENNderCare screens and interperiodic screens, must be medically necessary in order to be covered by the CONTRACTOR. The CONTRACTOR shall provide all medically necessary TENNderCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by a contract provider.

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)	MCO	
(2)(A) Outpatient hospital services	MCO	
(2)(B) Rural health clinic services (RHCs)	MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)	MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services	MCO	
(4)(A) Nursing facility services for individuals age 21 and older		Not applicable for TENNderCare
(4)(B) EPSDT services	MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services as described except as in Section 2.6.1.3	
(4)(C) Family planning services and supplies	MCO; PBM for pharmacy services except as described in Section 2.6.1.3	
(5)(A) Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility	MCO	
(5)(B) Medical and surgical services furnished by a dentist	DBM except as described in Section 2.6.1.3	

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law		MCO	See Item (13)
(7) Home health care services		MCO	
(8) Private duty nursing services		MCO	
(9) Clinic services		MCO	
(10) Dental services		DBM except as described in Section 2.6.1.3	
(11) Physical therapy and related services		MCO	
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses		MCO; PBM for pharmacy services except as described in Section 2.6.1.3; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	The following are considered practitioners of the healing arts in Tennessee law: ¹ <ul style="list-style-type: none"> • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel

¹ This list was provided by the Tennessee Department of Health.

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
		<ul style="list-style-type: none"> • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic

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Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			physician's office <ul style="list-style-type: none"> • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases			Not applicable for TENNderCare
(15) Services in an intermediate care facility for the mentally retarded		TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21		MCO	
(17) Services furnished by a nurse-midwife		MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care		MCO	
(19) Case management services		MCO	
(20) Respiratory care services		MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner		MCO	The MCOs are not required to contract with PNP's or CFNP's if the services are available through other contract providers.
(22) Home and community care for functionally disabled elderly individuals			Not applicable for TENNderCare
(23) Community supported living arrangements services			Not applicable for TENNderCare
(24) Personal care services		MCO	
(25) Primary care case management services			Not applicable
(26) Services furnished under a PACE program			Not applicable for TENNderCare
(27) Any other medical care, and any other type of remedial care recognized under state law.		MCO for physical and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	See Item (13)

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- 2.6.13.4.8.1 Note 1: "Targeted case management services," which are listed under Section 1915(g)(1), are not TENNderCare services except to the extent that the definition in Section 1915(g)(2) is used with Item (19) above.
- 2.6.13.4.8.2 Note 2: "Psychiatric residential treatment facility" is not listed in Social Security Act Section 1905(a). It is, however, defined in 42 CFR 483.352 as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age twenty-one (21), in an inpatient setting."
- 2.6.13.4.8.3 Note 3: "Rehabilitative" services are differentiated from "habilitative" services in federal law. "Rehabilitative" services, which are TENNderCare services, are defined in 42 CFR 440.130(d) as services designed "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." "Habilitative" services, which are not TENNderCare services, are defined in Section 1915(c)(5) as services designed "to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."
- 2.6.13.4.8.4 Note 4: Certain services are covered under a Home and Community Based waiver but are not TENNderCare services because they are not listed in the Social Security Act Section 1905(a). These services include habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)
- 2.6.13.4.8.5 Note 5: Certain services are not coverable even under a Home and Community Based waiver and are not TENNderCare services. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

2.6.13.5 Children with Special Health Care Needs

Children with special health care needs are those children who are in the custody of DCS. As provided in Section 2.4.4, TennCare enrollees who are in the custody of DCS will be enrolled in TennCare Select.

9. Section 2.6 shall be amended by adding a new Section 2.6.15 which shall read as follows:

2.6.15 **Cost Sharing for Services**

2.6.15.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by the State to the CONTRACTOR. Further, the CONTRACTOR and all providers and subcontractors shall not charge enrollees for missed appointments.

2.6.15.2 Preventive Services

TennCare cost sharing responsibilities shall apply to covered services other than the preventive services described in TennCare rules and regulations.

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2.6.15.3 Cost Sharing Schedule

The current TennCare cost sharing schedule is included in this Agreement as Attachment XII. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TENNCARE.

2.6.15.4 Provider Requirements

2.6.15.4.1 Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for covered services, including but not limited to, services that the State or the CONTRACTOR has not paid for, except as permitted by TennCare rules and regulations and as described below. Providers may seek payment from an enrollee only in the following situations.

2.6.15.4.1.1 If the services are not covered services and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider shall inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.15.4.1.2 If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.15.4.1.3 If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts shall be refunded when a claim is submitted to an MCO because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

2.6.15.4.1.4 If the services are not covered because they are in excess of an enrollee's hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

2.6.15.4.2 The CONTRACTOR shall require, as a condition of payment, that the provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Except in the circumstances described above, if the CONTRACTOR is aware that a provider, or a collection agency acting on the provider's behalf, bills an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. If a provider continues to bill an enrollee after notification by the CONTRACTOR, the CONTRACTOR shall refer the provider to the Tennessee Bureau of Investigation.

10. **The existing Sections 2-4 "Service Delivery Requirements", 2-5 "Services Not Covered", 2-6 "Marketing and Enrollee Materials", 2-7 "Medical Management", 2-8 "Complaints and Appeals", 2-9 "Administration and Management", 2-10 "Reporting Requirements", 2-11 "Accounting Requirements", 2-12 "Availability of Records", 2-13 "Audit Requirements", 2-**

14 "Independent Review of the CONTRACTOR, 2-15 "Accessibility of Monitoring", 2-16 "Changes Resulting from Monitoring and Audit", 2-17 "Use of Subcontracts", 2-18 "Provider Agreements", 2-19 "Fidelity Bonds – Net Worth", 2-20 "Insurance", 2-21 "Ownership and Financial Disclosure", 2-22 Community Service Area, 2-23 "CONTRACTOR Appeal Rights, 2-24 "Non-Discrimination Compliance", 2-25 "Processing and Payment of Supplemental Payments", 26 "Processing and Payment of Critical Access Hospital Payments", 2-27 "Processing and Payment of Essential Hospital Payments", 2-28 "Notice of Legal Action", and Section 2-29 "Prohibition of Illegal Immigrants" shall be deleted in their entirety and replaced by new Sections 2.7 through 2.30 as described below and all references thereto shall be amended accordingly.

2.7 LEFT BLANK INTENTIONALLY

2.8 DISEASE MANAGEMENT

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate a disease management (DM) program for each of the following conditions:

2.8.1.1.1 Maternity care management, in particular high-risk obstetrics;

2.8.1.1.2 Diabetes;

2.8.1.1.3 Congestive heart failure;

2.8.1.1.4 Asthma;

2.8.1.1.5 Coronary artery disease;

2.8.1.1.6 Chronic-obstructive pulmonary disease;

2.8.1.1.7 Bipolar disorder;

2.8.1.1.8 Major depression; and

2.8.1.1.9 Schizophrenia.

2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care. For the conditions listed in 2.8.1.1 through 2.8.1.6, the guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.

2.8.1.3 The DM programs shall emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

2.8.1.4 The CONTRACTOR shall develop and maintain DM program policies and procedures, which shall include program descriptions. These policies and procedures shall include, for each of the conditions listed above, the following:

2.8.1.4.1 The definition of the target population;

2.8.1.4.2 Member identification strategies;

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- 2.8.1.4.3 The guidelines;
- 2.8.1.4.4 Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
- 2.8.1.4.5 Program content;
- 2.8.1.4.6 Methods for informing and educating members;
- 2.8.1.4.7 Methods for informing and educating providers; and
- 2.8.1.4.8 Program evaluation.
- 2.8.1.5 As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

2.8.2 Member Identification Strategies

- 2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program.
- 2.8.2.2 The CONTRACTOR shall operate its disease management programs using an "opt out" methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.3 Stratification

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member provided information. The DM programs shall tailor the program content and education activities, for each stratification level.

2.8.4 Program Content

Each DM program shall include the development of treatment plans, as described in NCQA Disease Management program content, that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan shall address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues.

2.8.5 Informing and Educating Members

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

- 2.8.5.1 Are proactive and effective partners in their care;
- 2.8.5.2 Understand the appropriate use of resources needed for their care;
- 2.8.5.3 Identify precipitating factors and appropriate responses before they require more acute intervention; and
- 2.8.5.4 Are compliant and cooperative with the recommended treatment plan.

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2.8.6 Informing and Educating Providers

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

2.8.7 Program Evaluation (Satisfaction and Effectiveness)

2.8.7.1 The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction shall be specific to DM programs;

2.8.7.1.1 A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.

2.8.7.2 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include:

2.8.7.2.1 Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;

2.8.7.2.2 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.2.3 Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the maternity care management program;

2.8.7.2.4 Appropriate HEDIS measures;

2.8.7.2.5 The passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;

2.8.7.2.6 Cost savings;

2.8.7.2.7 Member adherence to treatment plans; and

2.8.7.2.8 Provider adherence to the guidelines.

2.8.7.3 The CONTRACTOR shall report on DM activities as required in Section 2.30.5.

2.8.8 Obesity Disease Management

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.7). The CONTRACTOR may fulfill this requirement by entering into a provider agreement with Weight Watchers and then referring/authorizing eligible obese and overweight members to participate in a Weight Watchers program. If the CONTRACTOR identifies another weight management program as the cost effective alternative service, the CONTRACTOR shall include a narrative of the program (including target population and description of services) as part of its quarterly disease management report (see Section 2.30.5.1) applicable to the quarter in which the program was implemented.

2.9 SERVICE COORDINATION

2.9.1 General

- 2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility.
- 2.9.1.2 The CONTRACTOR shall:
 - 2.9.1.2.1 Coordinate care for children in DCS custody;
 - 2.9.1.2.2 Coordinate care between PCPs and specialists;
 - 2.9.1.2.3 Perform reasonable preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;
 - 2.9.1.2.4 Document authorized referrals in its utilization management system;
 - 2.9.1.2.5 Monitor members with ongoing medical or behavioral health conditions;
 - 2.9.1.2.6 Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home;
 - 2.9.1.2.7 Maintain and operate a formalized hospital and/or institutional discharge planning program;
 - 2.9.1.2.8 Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;
 - 2.9.1.2.9 Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member; and
 - 2.9.1.2.10 Authorize services provided by non-contract providers, as required in this Agreement (see, e.g., Section 2.13).

2.9.2 Transition of New Members

- 2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) calendar days however the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.
- 2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

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- 2.9.2.3 In the event an enrollee entering the CONTRACTOR's MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period.
- 2.9.2.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.15 and in Attachment XII of this Agreement.
- 2.9.2.5 The CONTRACTOR shall develop and maintain policies and procedures regarding the transition of new members.

2.9.3 Transition of Care

- 2.9.3.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions in transitioning to another provider when their current provider has terminated participation with the CONTRACTOR. The CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption of care, whichever is less. The CONTRACTOR shall allow continued access to the provider through the postpartum period for members in their second or third trimester of pregnancy.
- 2.9.3.2 The CONTRACTOR shall actively assist members in transitioning to another provider when there are changes in providers. The CONTRACTOR shall have transition policies that, at a minimum, include the following:
 - 2.9.3.2.1 A schedule which ensures transfer does not create a lapse in service;
 - 2.9.3.2.2 A mechanism for timely information exchange (including transfer of the member record);
 - 2.9.3.2.3 A mechanism for assuring confidentiality;
 - 2.9.3.2.4 A mechanism for allowing a member to request and be granted a change of provider;
 - 2.9.3.2.5 An appropriate schedule for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.
 - 2.9.3.2.6 Specific transition language on the following special populations:
 - 2.9.3.2.6.1 Children who are SED;
 - 2.9.3.2.6.2 Adults who are SPMI;
 - 2.9.3.2.6.3 Persons who have addictive disorders;
 - 2.9.3.2.6.4 Persons who have co-occurring disorders of both mental health and substance abuse disorders; and
 - 2.9.3.2.6.5 Persons with behavioral health conditions who also have a developmental disorder (dually diagnosed). These members shall be allowed to remain with their providers of the services listed below for the minimum time frames set out below as long as the services continue to be medically necessary. The CONTRACTOR may shorten these transition time frames only when the provider of services is no longer available to serve the member or when a change in providers is agreed to in writing by the member.
 - 2.9.3.2.6.5.1 Mental health case management: three (3) months;

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- 2.9.3.2.6.5.2 Psychiatrist: three (3) months;
- 2.9.3.2.6.5.3 Outpatient behavioral health therapy: three (3) months;
- 2.9.3.2.6.5.4 Psychosocial rehabilitation and supported employment: three (3) months; and
- 2.9.3.2.6.5.5 Psychiatric inpatient or residential treatment and supportive housing: six (6) months.

2.9.4 MCO Case Management

- 2.9.4.1 The CONTRACTOR shall maintain an MCO case management program that includes the following components:
 - 2.9.4.1.1 A systematic approach to identify eligible members;
 - 2.9.4.1.2 Assessment of member needs;
 - 2.9.4.1.3 Development of an individualized plan of care;
 - 2.9.4.1.4 Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
 - 2.9.4.1.5 Program Evaluation (Satisfaction and Effectiveness).
- 2.9.4.2 The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:
 - 2.9.4.2.1 Members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.
- 2.9.4.3 The CONTRACTOR has the option of allowing members to be enrolled in both MCO case management and a disease management program.
- 2.9.4.4 Eligible members shall be offered MCO case management services. However, member participation shall be voluntary.
- 2.9.4.5 The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP and/or appropriate specialist when a member has been assigned to the MCO case management program.
- 2.9.4.6 The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM (see Section 2.9.7), to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member exceeded the ED threshold (see Section 2.14.1.10.2).

2.9.5 Coordination and Collaboration Between Physical Health and Behavioral Health

2.9.5.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health and behavioral health services. The CONTRACTOR shall ensure communication and coordination between PCPs and medical specialists. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical and behavioral health services and ensuring collaboration between physical health and behavioral health providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical and behavioral health providers, exchange of information, confidentiality, assessment, treatment plan development, collaboration, MCO

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case management and disease management, provider training, and monitoring implementation and outcomes.

2.9.5.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding, at a minimum, the items identified in Section 2.9.5.1 as well as prior authorization, claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section 2.26 of this Agreement.

2.9.5.3 Screening for Behavioral Health Needs

2.9.5.3.1 The CONTRACTOR shall ensure that the need for behavioral health services is systematically identified by and addressed by the member's PCP at the earliest possible time following initial enrollment of the member in the CONTRACTOR's MCO or after the onset of a condition requiring mental health and/or substance abuse treatment.

2.9.5.3.2 The CONTRACTOR shall encourage PCPs and other providers to use a screening tool prior approved in writing by the State as well as other mechanisms to facilitate early identification of behavioral health needs.

2.9.5.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly members with SED/SPMI are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information.

2.9.5.5 Referrals to PCPs

The CONTRACTOR shall ensure that members with both physical health and behavioral health needs are appropriately referred to their PCPs for treatment of their physical health needs. The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need physical health services. The CONTRACTOR shall develop a referral process to be used by its providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health provider.

2.9.5.6 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services.

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2.9.5.7 MCO Case Management and Disease Management

The CONTRACTOR shall use its MCO case management and disease management programs (see Sections 2.9.4 and 2.9) to support the continuity and coordination of covered physical and behavioral health services and the collaboration between physical health and behavioral health providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on disease management stratification (see Section 2.8.3), to be enrolled in both a disease management program and MCO case management.

2.9.5.8 Monitoring

The CONTRACTOR shall evaluate and monitor the effectiveness of its policies and procedures regarding the continuity and coordination of covered physical and behavioral health services and collaboration between physical and behavioral health providers. This shall include, but not be limited to, an assessment of the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; an evaluation of the appropriateness of psychopharmacological medication; and analysis of data regarding access to appropriate services. Based on these monitoring activities, the CONTRACTOR shall develop and implement interventions to improve continuity, coordination, and collaboration for physical and behavioral health services.

2.9.6 **Coordination and Collaboration Among Behavioral Health Providers**

2.9.6.1 The CONTRACTOR shall ensure communication and coordination between mental health providers and substance abuse providers, including:

2.9.6.1.1 Assignment of a responsible party to ensure communication and coordination occur;

2.9.6.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers; screening and assessment tools to be designated by TENNCARE;

2.9.6.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers; screening and assessment tools to be designated by TENNCARE;

2.9.6.1.4 Description of how treatment plans will be coordinated between behavioral health service providers; and

2.9.6.1.5 Assessment of cross training of behavioral health providers: mental health providers being trained on substance abuse issues and substance abuse providers being trained on mental health issues.

2.9.6.2 The CONTRACTOR shall ensure coordination between the children and adolescent service delivery system as they transition into the adult mental health service delivery system, through such activities as communicating treatment plans and exchange of information.

2.9.6.3 The CONTRACTOR shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

2.9.6.3.1 The outpatient provider shall be involved in the admissions process when possible; if the outpatient provider is not involved, the outpatient provider shall be notified promptly of the member's hospital admission;

2.9.6.3.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan in which the member has participated (an outpatient visit shall be scheduled before discharge, which ensures access to proper provider/medication follow-up; also, an appropriate placement or housing site shall be secured prior to discharge);

2.9.6.3.3 An evaluation shall be performed prior to discharge to determine if mental health case management services are medically necessary. Once deemed medically necessary, the mental

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health case manager shall be involved in discharge planning; if there is no mental health case manager, then the outpatient provider shall be involved; and

2.9.6.3.4 A procedure to ensure continuity of care regarding medication shall be developed and implemented.

2.9.6.4 The CONTRACTOR shall identify and develop community alternatives to inpatient hospitalization for those members who are receiving inpatient psychiatric facility services who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the CONTRACTOR does not provide appropriate community alternatives, the CONTRACTOR shall remain financially responsible for the continued inpatient care of these individuals.

2.9.6.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section 2.9.6.3.2.

2.9.7. Coordination of Pharmacy Services

2.9.7.1 Except as provided in Section 2.6.1.3, the CONTRACTOR is not responsible for the provision and payment of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.

2.9.7.2 The CONTRACTOR shall accept and maintain prescription drug data from TENNCARE or its PBM.

2.9.7.3 The CONTRACTOR shall monitor and manage members by, at a minimum, conducting the activities as described below:

2.9.7.3.1 Analyzing prescription drug data and/or reports provided by the PBM to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to the MCO case management and/or disease management programs as appropriate;

2.9.7.3.2 Analyzing prescription drug data and/or reports provided by the PBM to identify potential pharmacy lock-in candidates and referring them to TENNCARE; and

2.9.7.3.3 Regularly providing information to members about appropriate prescription drug usage. At a minimum, this information shall be included in the Member Handbook and in at least two (2) quarterly member newsletters within a twelve (12) month period.

2.9.7.4 The CONTRACTOR shall monitor and manage providers' prescription patterns by, at a minimum, conducting the activities described below:

2.9.7.4.1 Collaborating with the PBM to educate the MCO's contract providers regarding compliance with the State's preferred drug list (PDL) and appropriate prescribing practices; and

2.9.7.4.2 Intervening with contract providers whose prescribing practices appear to be operating outside industry or peer norms as defined by TENNCARE, are non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns, and/or who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices among the identified contract providers, as appropriate. Interventions shall be personal and one-on-one.

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2.9.7.5 At any time, upon request from TENNCARE, the CONTRACTOR shall provide assistance in educating, monitoring and intervening with providers. For example, TENNCARE may require assistance in monitoring and intervening with providers regarding prescribing patterns for narcotics.

2.9.8 **Coordination of Dental Benefits**

2.9.8.1 General

2.9.8.1.1 The CONTRACTOR is not responsible for the provision and payment of dental benefits; TENNCARE contracts with a dental benefits manager (DBM) to provide these services.

2.9.8.1.2 As provided in Section 2.6.1.3, the CONTRACTOR is responsible for transportation to and from dental services as well as the facility, medical and anesthesia services related to medically necessary and approved dental services that are not provided by a dentist or in a dentist's office.

2.9.8.1.3 The CONTRACTOR may require prior authorization for services related to dental services including the facility, anesthesia, and/or medical services related to the dental service. However, the CONTRACTOR may waive authorization of said services based upon authorization of the dental services by the dental benefits manager. The CONTRACTOR shall approve and arrange transportation to and from dental services in accordance with this Agreement, including but not limited to Attachment XIV.

2.9.8.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

2.9.8.2.1 Means for referral that ensures immediate access for emergency care and provision of urgent and routine care according to TennCare guidelines for specialty care (see Attachment III);

2.9.8.2.2 Means for the transfer of information (to include items before and after the visit);

2.9.8.2.3 Maintenance of confidentiality;

2.9.8.2.4 Resolving disputes related to prior authorizations and claims and payment issues; and

2.9.8.2.5 Cooperation with the DBM regarding training activities provided by the DBM.

2.9.8.3 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM. However, the CONTRACTOR shall provide coordination assistance and shall be responsible for communicating the DBM provider services, provider relations, and/or claim coordinator contact information to all of its contract providers. With respect to specific member issues, the CONTRACTOR shall work with the DBM coordinator towards a resolution. Should systemic issues arise, the CONTRACTOR shall meet and resolve the issues with the DBM. In the event that such issues cannot be resolved, the MCO and the DBM shall meet with TENNCARE to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) calendar days from referral to TENNCARE.

2.9.8.4 Resolution of Requests for Prior Authorization

2.9.8.4.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare enrollee. The CONTRACTOR shall

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require that its care coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for prior authorization that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM with a list of its care coordinators and telephone number(s) at which each care coordinator may be contacted. When the CONTRACTOR receives a request for prior authorization from a provider for a member and the CONTRACTOR believes the service is the responsibility of the DBM, the CONTRACTOR's care coordinator shall contact the DBM's care coordinator by the next business day after receiving the request for prior authorization. The care coordinator shall also contact the member and/or member's provider. For routine requests contact to the member or member's provider shall be made within fourteen (14) days or less of the provider's request for prior authorization and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations. For urgent requests, contact shall be made immediately after receiving the request for prior authorization.

2.9.8.4.2 The CONTRACTOR shall assign staff members to serve on a coordination committee with DBM staff members. This committee shall be responsible for addressing all issues of dental care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The CONTRACTOR and the DBM shall attempt in good faith to resolve any dispute and communicate the decision to the provider requesting prior authorization of a service. In the event the CONTRACTOR and the DBM cannot agree within ten (10) calendar days of the provider's request for prior authorization, the party who first received the request from the provider shall be responsible for prior authorization and payment to the contract provider within the time frames designated by TENNCARE. The CONTRACTOR and the DBM are responsible for enforcing hold harmless protection for the member. The CONTRACTOR shall ensure that any response to a request for authorization shall not exceed fourteen (14) calendar days and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations.

2.9.8.5 Claim Resolution Processes

2.9.8.5.1 The CONTRACTOR shall designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to also designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM and TennCare, with a list of its claims coordinators and telephone number(s) at which each claims coordinator may be contacted.

2.9.8.5.2 When the CONTRACTOR receives a disputed claim for payment from a provider for a member and believes care is the responsibility of the DBM, the CONTRACTOR's claims coordinators shall contact the DBM's claims coordinators within four (4) calendar days of receiving such claim for payment. If the CONTRACTOR's claims coordinator is unable to reach agreement with the DBM's claims coordinators on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee (described below) for review.

2.9.8.5.3 The CONTRACTOR shall assign claims coordinators and other representatives, as needed, to a joint CONTRACTOR/DBM Claims Coordination Committee. The number of members serving on the Claims Coordination Committee shall be determined within ten (10) calendar days of the execution of this Agreement by the mutual agreement of the DBM and MCO. The CONTRACTOR shall, at a minimum, assign two (2) representatives to the committee. The make-up of the committee may be revisited from time to time during the term of this Agreement. The Claims Coordination Committee shall review any disputes and negotiate responsibility between the CONTRACTOR and the DBM. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party shall

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reimburse and abide by the prior decisions of that party. Reimbursement shall be made within ten (10) calendar days of the Claims Coordination Committee's decision.

- 2.9.8.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to both the CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s) as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.
- 2.9.8.5.5 If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days of the meeting, submit a Request for Resolution of the dispute to the State or the State's designee for a decision on responsibility.
- 2.9.8.5.6 The process before the submission of a Request for Resolution, as described above, shall be completed within thirty (30) calendar days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) calendar days of receiving the claim for payment, the MCO and the DBM shall be responsible for enforcing hold harmless protections for the member and the party who first received the request or claim from the provider shall be responsible for authorization and payment to the provider in accordance with the requirements of the MCO's or DBM's respective Contract/contract with the State of Tennessee. Moreover, the party that first received the request or claim from the provider shall also make written request of all requisite documentation for payment and shall provide written reasons for any denial.
- 2.9.8.5.7 The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable Contract/contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution.
- 2.9.8.5.8 The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information ("Decision"). The Decision may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The Decision shall be determined solely by the State, or its designee, based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars (\$1,000), for each Request for Resolution. The amount of the DBM's or MCO's payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party's payment responsibility as described in this Section, Section 2.9.8.5.8, within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

2.9.8.6 Denial, Delay, Reduction, Termination or Suspension

The CONTRACTOR agrees that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim shall be approved or disapproved based on the definition of emergency services specified in this Agreement.

2.9.8.7 Emergencies

Prior authorization shall not be required for emergency services prior to stabilization.

2.9.8.8 Claims Processing Requirements

All claims shall be processed in accordance with the requirements of the MCO's and DBM's respective Agreements/contracts with the State of Tennessee.

2.9.8.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq.* Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section 2.9.8.

2.9.8.10 Duties and Obligations

The existence of any dispute under this Agreement shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective obligations, including their obligations established in their respective Agreements/contracts with the State pending resolution of the dispute under this Section, Section 2.9.8.10. In accordance with TCA 56-32-126(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.8.11 Confidentiality

2.9.8.11.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, to cooperate with the State to develop confidentiality guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards shall apply to both DBM's and MCO's providers and staff. If the CONTRACTOR or DBM believes that the standards require updating, or operational changes are needed to enforce the standards, the CONTRACTOR shall meet with the DBM to resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

2.9.8.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22, Section 6.22 of this Agreement, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those requirements or to TENNCARE, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.8.12 Access to Service

The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to establish methods of referral which ensure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2.9.9 Coordination with Medicare

2.9.9.1 The CONTRACTOR is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

2.9.9.2 The CONTRACTOR shall ensure that services covered and provided pursuant to this Agreement are delivered without charge to members who are dually eligible for Medicare and Medicaid services.

2.9.9.3 The CONTRACTOR shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

2.9.10 Institutional Services and Alternatives to Institutional Services

2.9.10.1 For members enrolled in the long-term care program, the CONTRACTOR is not responsible for long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to these institutional services. However, should the CONTRACTOR utilize nursing facility services as a cost-effective alternative to continued inpatient hospitalization, the CONTRACTOR shall be responsible for payment of such services. Further, to the extent that services available to a member through a HCBS waiver are also covered services pursuant to this Agreement, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS waiver services may supplement, but not supplant, medically necessary covered services. Except as noted above, long-term care services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

2.9.10.2 The CONTRACTOR is responsible for covered services for members residing in long-term care institutions or enrolled in a HCBS waiver. For members residing in long-term care institutions, the CONTRACTOR is responsible for providing covered services that are not included in the per diem reimbursement for institutional services (e.g., prosthetics, some items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). Except as provided below for NEMT, for members enrolled in a HCBS waiver, the CONTRACTOR shall provide all medically necessary covered services, including covered services that may also be provided through the HCBS waiver. The HCBS waiver is the payor of last resort. However, the CONTRACTOR is not responsible for providing non-emergency medical transportation (NEMT) to any service that is being provided to the member through the HCBS waiver (see Section 2.6.1.3).

2.9.10.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by institutional and HCBS waiver providers to minimize disruption and duplication of services.

2.9.10.4 The CONTRACTOR shall use its best efforts to increase the use of HCBS waivers as an alternative to long-term care institutions. This should include educating members entering or recently admitted to a long-term care institution, as well as their providers, about available HCBS waivers and coordinating with the Commission on Aging and Disability and TennCare Bureau, Long Term Care Division, as needed and as requested by TENNCARE.

2.9.11 Enrollees with Special Health Care Needs

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- 2.9.11.1 The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having Special Health Care Needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement. For purposes of Section 2.9.11, enrollees with Special Health Care Needs shall refer to enrollees identified through the Department of Children's Services (DCS), as described in Section 1-3 of this Agreement.
- 2.9.11.2 The CONTRACTOR shall implement procedures to share, with other MCOs, DBMs and PBMs (as necessary) serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.

2.9.12 Inter-Agency Coordination

The CONTRACTOR shall coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with:

- 2.9.12.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) for the purpose of interfacing with and assuring continuity of care;
- 2.9.12.2 Tennessee Department of Children's Services (DCS) for the purpose of interfacing with, assuring continuity of care, and assuring the provision of covered services to children in or transitioning out of state custody;
- 2.9.12.3 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;
- 2.9.12.4 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;
- 2.9.12.5 The Division of Mental Retardation Services (DMRS), for the purposes of interfacing with and assuring continuity of care;
- 2.9.12.6 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;
- 2.9.12.6.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system.
- 2.9.12.6.2 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the CONTRACTOR shall:

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- 2.9.12.6.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.
- 2.9.12.6.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.
- 2.9.12.6.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within 14 days of the CONTRACTOR's receipt of the IEP.
- 2.9.12.7 Commission on Aging and Disability and TennCare Bureau, Long Term Care Division for the purposes of coordinating care for members requiring long-term care services; and
- 2.9.12.8 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

2.10 SERVICES NOT COVERED

Except as authorized pursuant to Section 2.6.7 of this Agreement, the CONTRACTOR shall not pay for non-covered services as described in TennCare rules and regulations.

2.11 PROVIDER NETWORK

2.11.1 General Provisions

- 2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section 2.6.1 of this Agreement. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the Terms and Conditions for Access which is part of the TennCare waiver and is contained herein as Attachment III, the Specialty Network Standards in Attachment IV, the Access and Availability for Behavioral Health Services in Attachment V and the requirements herein. These minimum requirements shall not release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.
- 2.11.1.2 The CONTRACTOR may provide covered services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered services to the members in exchange for payment by the CONTRACTOR for services rendered.
- 2.11.1.3 Should the CONTRACTOR elect to contract with providers (as opposed to using staff providers) and develop a network for the provision of covered services, the CONTRACTOR shall:
 - 2.11.1.3.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program;
 - 2.11.1.3.2 Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Agreement; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of

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transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;

- 2.11.1.3.3 Have in place, written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;
- 2.11.1.3.4 Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination;
- 2.11.1.3.5 Give affected providers written notice if it declines to include individual or groups of providers in its network; and
- 2.11.1.3.6 Maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section 2.12 of this Agreement.
- 2.11.1.4 Section 2.11.1.3 shall not be construed to:
 - 2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Agreement;
 - 2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; or
 - 2.11.1.4.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.
- 2.11.1.5 The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
 - 2.11.1.5.1 The member's health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered;
 - 2.11.1.5.2 Any information the member needs in order to decide among all relevant treatment options;
 - 2.11.1.5.3 The risks, benefits, and consequences of treatment or non-treatment; or
 - 2.11.1.5.4 The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable; and has obtained a Medicaid provider number from TENNCARE.
- 2.11.1.7 If a member requests a provider located outside the access standards, and the CONTRACTOR has an appropriate provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall not be responsible for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider.

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- 2.11.1.8 If the CONTRACTOR is unable to meet the access standards for a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.
- 2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section 2.9.3.
- 2.11.1.10 The CONTRACTOR shall monitor provider compliance with applicable access requirements, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.7.2.
- 2.11.1.11 The CONTRACTOR shall use its best efforts to contract with providers to whom the CONTRACTOR routinely refers members.
- 2.11.1.12 TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify any provider agreement when TENNCARE determines it to be in the best interest of the State.
- 2.11.1.13 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section 2.30.7.

2.11.2 Primary Care Providers (PCPs)

- 2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member.
- 2.11.2.2 The CONTRACTOR shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and behavioral health needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the Terms and Conditions for Access provided in Attachment III.
- 2.11.2.3 To the extent feasible and appropriate, the CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.
- 2.11.2.4 The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform all responsibilities of a PCP as defined in Section 1.
- 2.11.2.5 Children in state custody shall be assigned to a Best Practice Network Primary Care Provider as specified in Section 3 of this Agreement.
- 2.11.2.6 If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.
- 2.11.2.7 The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time

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greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR shall include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.

2.11.2.8 If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR shall allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2.11.3 **Specialty Service Providers**

2.11.3.1 Essential Hospital Services and Centers of Excellence

2.11.3.1.1 The CONTRACTOR shall demonstrate sufficient access to essential hospital services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:

2.11.3.1.1.1 Neonatal services;

2.11.3.1.1.2 Perinatal services;

2.11.3.1.1.3 Pediatric services;

2.11.3.1.1.4 Trauma services; and

2.11.3.1.1.5 Burn services.

2.11.3.1.2 The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH.

2.11.3.1.3 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for Behavioral Health located within the Grand Region(s) served by the CONTRACTOR.

2.11.3.1.4 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for children in, or at risk of state custody, as identified by TennCare.

2.11.3.2 Physician Specialists

2.11.3.2.1 The CONTRACTOR shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

2.11.3.2.1.1 The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and

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- 2.11.3.2.1.2 The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, IV, and V.
- 2.11.3.3 TENNCARE Monitoring
 - 2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2.30.7.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.
 - 2.11.3.3.2 TENNCARE will require a corrective action plan from the CONTRACTOR when:
 - 2.11.3.3.2.1 Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;
 - 2.11.3.3.2.2 Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or
 - 2.11.3.3.2.3 The member to provider ratio exceeds that listed in Attachment IV.
 - 2.11.3.3.3 TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:
 - 2.11.3.3.3.1 The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;
 - 2.11.3.3.3.2 A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;
 - 2.11.3.3.3.3 For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;
 - 2.11.3.3.3.4 A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;
 - 2.11.3.3.3.5 Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;
 - 2.11.3.3.3.6 Documentation of how these arrangements are communicated to the member; and
 - 2.11.3.3.3.7 Documentation of how these arrangements are communicated to the PCPs.

2.11.4 Special Conditions for Prenatal Care Providers

- 2.11.4.1 The CONTRACTOR shall have a sufficient number of contract providers who accept members in accordance with TennCare access standards in Attachment III so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.
- 2.11.4.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections 2.6.12 and 2.11.4).

2.11.5 Special Conditions for Behavioral Health Services

- 2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity.
- 2.11.5.2 The CONTRACTOR shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents with a co-occurring mental health and substance abuse disorder.
- 2.11.5.3 The CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by TENNCARE unless the State approves the use of other crisis service providers.

2.11.6 Safety Net Providers

2.11.6.1 Federally Qualified Health Centers (FQHCs)

- 2.11.6.1.1 The CONTRACTOR is encouraged to contract with FQHCs and other safety net providers (e.g., rural health clinics) in the CONTRACTOR's service area to the extent possible and practical. Where FQHCs are not utilized, the CONTRACTOR shall demonstrate to DHHS, the Tennessee DHS and TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with FQHCs.

- 2.11.6.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section 2.30.7.6 of this Agreement.

2.11.6.2 Community Mental Health Agencies (CMHAs)

The CONTRACTOR is encouraged to contract with CMHAs and other behavioral health safety net providers in the CONTRACTOR's service area to the extent possible and practical. Where CMHAs are not utilized, the CONTRACTOR shall demonstrate that both adequate capacity and an appropriate range of services for all populations, but in particular SPMI/SED populations, exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with CMHAs.

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2.11.6.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in the Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.6.

2.11.7 **Credentialing and Other Certification**

2.11.7.1 Credentialing of Contract Providers

2.11.7.1.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.7.1.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.7.2 Credentialing of Non-Contract Providers

2.11.7.2.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

2.11.7.2.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.7.3 Credentialing of Behavioral Health Entities

2.11.7.3.1 The CONTRACTOR shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.

2.11.7.3.2 When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the CONTRACTOR to ensure, based on applicable state licensure rules and/or programs standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

2.11.7.4 Compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

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2.11.7.5 Weight Watchers Centers or Other Weight Management Program

The CONTRACTOR is not required to credential Weight Watchers centers(s) or another weight management program used as a cost effective alternative service pursuant to Section 2.8.8 of this Agreement.

2.11.8 **Network Notice Requirements**

2.11.8.1 Member Notification

All member notices required shall be written using the appropriate notice template provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.11.8.1.1 *Change in PCP*

The CONTRACTOR shall immediately provide written notice to a member when the CONTRACTOR changes the member's PCP. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances necessitating a PCP change.

2.11.8.1.2 *PCP Termination*

If a PCP ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as their PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.3 *Providers Providing Ongoing Treatment Termination*

If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been patients of the non-PCP provider. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

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2.11.8.1.5 *Network Deficiency*

Upon notification from TENNCARE that a corrective action plan designed to remedy a network deficiency has not been accepted, the CONTRACTOR shall immediately provide written notice to members living in the affected area of a provider shortage in the CONTRACTOR's network.

2.11.8.2 TENNCARE Notification

2.11.8.2.1 *Subcontractor Termination*

When a subcontract that relates to the provision of services to members or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI. Said notices shall include, at a minimum: a CONTRACTOR's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide a transition plan to TENNCARE within fifteen (15) calendar days, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition and how continuity of care will be maintained for the members.

2.11.8.2.2 *Hospital Termination*

Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the hospital or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the TENNCARE no less than thirty (30) calendar days prior to the effective date of the termination.

2.11.8.2.3 *Other Provider Terminations*

2.11.8.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit a copy of one of the actual member notices mailed as well as an electronic listing in Excel format that includes the provider's name, TennCare provider identification number, and NPI number and identifies each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 2.11.8.1. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR.

2.11.8.2.3.2 If termination of the CONTRACTOR's provider agreement with any PCP or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2.11 and Attachments III, IV and V, such termination shall be reported by the CONTRACTOR in writing to TENNCARE, in the standard format provided by TENNCARE to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

2.12 PROVIDER AGREEMENTS

2.12.1 Provider agreements, as defined in Section 1 of this Agreement, shall be administered in accordance with this Agreement and shall contain all of the items listed in this Section 2.12.

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- 2.12.2 All template provider agreements and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.
- 2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.
- 2.12.4 All single case agreements shall be reported to TENNCARE in accordance with Section 2.30.8; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears single case agreements are being used to circumvent the provider agreement review and approval process.
- 2.12.5 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement.
- 2.12.6 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.
- 2.12.7 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, at a minimum, meet the following requirements:
- 2.12.7.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;
 - 2.12.7.2 Specify the effective dates of the provider agreement;
 - 2.12.7.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
 - 2.12.7.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior written approval of the CONTRACTOR;
 - 2.12.7.5 Identify the population covered by the provider agreement;
 - 2.12.7.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
 - 2.12.7.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
 - 2.12.7.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;
 - 2.12.7.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;
 - 2.12.7.10 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR

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- and include the definition of unreasonable delay as described in Section 2.6.12 of this Agreement;
- 2.12.7.11 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- 2.12.7.12 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);
- 2.12.7.13 Include a statement that as a condition of participation in TennCare, enrollees shall give TENNCARE, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;
- 2.12.7.14 Include medical records requirements found in Section 2.24.4 of this Agreement;
- 2.12.7.15 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;
- 2.12.7.16 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;
- 2.12.7.17 Provide for monitoring, whether announced or unannounced, of services rendered to members;
- 2.12.7.18 Provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;
- 2.12.7.19 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and

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- provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;
- 2.12.7.20 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- 2.12.7.21 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;
- 2.12.7.22 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;
- 2.12.7.23 Provide the name and address of the official payee to whom payment shall be made;
- 2.12.7.24 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;
- 2.12.7.25 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;
- 2.12.7.26 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section 2.22.4 of this Agreement;
- 2.12.7.27 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;
- 2.12.7.28 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;
- 2.12.7.29 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.15 of this Agreement;
- 2.12.7.30 Specify the provider's responsibilities regarding third party liability (TPL);
- 2.12.7.31 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

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- 2.12.7.31.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and
- 2.12.7.31.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;
- 2.12.7.32 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;
- 2.12.7.33 As a condition of reimbursement for global procedure codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;
- 2.12.7.34 Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;
- 2.12.7.35 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;
- 2.12.7.36 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);
- 2.12.7.37 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State.
- 2.12.7.38 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 6.2 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;
- 2.12.7.39 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);
- 2.12.7.40 Include a Conflict of Interest clause as stated in Section 6.7 of this Agreement, Gratuities clause as stated in Section 6.11 of this Agreement, and Lobbying clause as stated in Section 6.12 of this Agreement between the CONTRACTOR and TENNCARE;

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- 2.12.7.41 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section 5.20 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;
- 2.12.7.42 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 5.22 of this Agreement;
- 2.12.7.43 Specify provider actions to improve patient safety and quality;
- 2.12.7.44 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:
 - 2.12.7.44.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and
 - 2.12.7.44.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.12.7.45 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;
- 2.12.7.46 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;
- 2.12.7.47 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;
- 2.12.7.48 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.6.13 of this Agreement. All provider agreements shall contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or include language to require that these sections be furnished to the provider upon request;
- 2.12.7.49 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TENNCARE;
- 2.12.7.50 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

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- 2.12.7.51 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;
- 2.12.7.52 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B; and
- 2.12.7.53 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them have 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) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members;
- 2.12.7.54 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.
- 2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in 2.12.7 above.
- 2.12.9 The provider agreement with a local health department (see Section 2.11.6.3) shall meet the minimum requirements specified above and shall also specify for the purpose of TENNderCare screening services: (1) that the local health department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TENNderCare screening services.
- 2.12.10 The provider agreement for CRG/TPG assessments shall meet the minimum requirements specified above and shall also specify that all CRG/TRG assessments detailed in Section 2.6.5.9 are completed by State-certified raters and that the assessments are completed within the specified time frames. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination, scored only by State-certified trainers.

2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

2.13.1 General

- 2.13.1.1 Maximum Allowable Rates. Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare with the following exceptions:
 - 2.13.1.1.1 The payment rate for an initial EPSDT screening conducted by a Best Practice Network Primary Care Provider for a child in state custody shall be at the rate specified in Section 2.13.2.1.
 - 2.13.1.1.2 The payment rate for all other preventive health services specified below for children (under age 21) may be increased up to 85% of the 2001 Medicare fee-schedule, unless otherwise specified by TENNCARE.

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2.13.1.1.2.1 The CONTRACTOR shall make an enhanced payment, defined as eighty-five percent (85%) of the 2001 Medicare fee-schedule or the BlueCare reimbursement rates in effect as of March 1, 2001, whichever is greater, to Primary Care Providers for the provision of the following preventive medical services identified by the CPT procedure codes listed below, when billed for children less than 21 years of age. Payment rates for services reimbursed as a percentage of average wholesale price shall be adjusted in accordance with Section 2.13.1.1.4. of this Agreement.

Office Visits

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Evaluation of Normal newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

Counseling and Risk Factor Reduction Intervention

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Other Preventive Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90700 – 90744	Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

- 2.13.1.1.3 The payment rate for all services that are reimbursed as a percentage of average wholesale prices shall be adjusted with fluctuations in the average wholesale price. However, the “percentage” applied to determine the payment amount shall be equivalent to the percentage applied for BlueCare as of March 1, 2001.
- 2.13.1.1.4 The initial utilization management and referral processes and requirements impacting provider reimbursement shall be those in effect for BlueCare and TennCare Select as of July 1, 2001. However, the State reserves the right to require the CONTRACTOR to modify these processes and requirements. The CONTRACTOR shall have sixty (60) days from the date of request to implement requested modifications.
- 2.13.1.1.5 If there is a network deficiency that necessitates additional funding to remedy, the CONTRACTOR shall attempt to negotiate a reasonable rate on behalf of the State prior to recommending an increase in reimbursement rates. Once the negotiations are concluded, the CONTRACTOR shall submit a recommendation to the State in writing with supporting documentation justifying an increase in reimbursement rates. The CONTRACTOR may not implement a recommended change until receipt of written approval from TennCare.

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- 2.13.1.2 Annual Review of Maximum Allowable Rates. The maximum allowable reimbursement rates shall be reviewed on an annual basis.
- 2.13.1.3 All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State. The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with this Agreement. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.
- 2.13.1.4 The claims payment amount shall not include payment for enrollee cost-sharing amounts.
- 2.13.1.5 The CONTRACTOR shall require, as a condition of payment, that the provider (contract or non-contract provider) accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.
- 2.13.1.6 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Agreement, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.
- 2.13.1.7 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.15 and in Attachment XII of this Agreement.
- 2.13.1.8 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2.12.7.52 of this Agreement.
- 2.13.1.9 Except where required by the Contractor's Contract with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility or after the termination date in the CONTRACTOR's plan. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's plan.
- 2.13.1.10 The CONTRACTOR shall prepare checks for payment of providers for the provision of covered services on a weekly basis, unless an alternative payment schedule is approved by TENNCARE.
- 2.13.1.10.1 The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks.
- 2.13.1.10.2 The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice.
- 2.13.1.10.3 The CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State.
- 2.13.1.10.4 The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR.
- 2.13.1.11 For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and

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media described by TENNCARE to support the payments released to providers by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

2.13.1.12 The CONTRACTOR shall provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

2.13.1.13 Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

2.13.2 Best Practice Network Requirements

2.13.2.1 Enhanced Initial EPSDT Screening Rate

The CONTRACTOR shall make an enhanced payment to Best Practice Network Primary Care Providers and Health Departments for the initial EPSDT examination for children in state custody, when all seven (7) components of the exam have been completed. The seven components shall include: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory testes appropriate for age and risk; (5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).

2.13.2.1.1 The procedure codes to be utilized when billing for the initial EPSDT exam are specified below. This language does not preclude the BPN-PCP from billing for other services separately, consistent with the CONTRACTOR's procedures for claims processing (e.g., lab). It is the responsibility of the CONTRACTOR to include in its Best Practice Network provider agreements a requirement that all seven components of the EPSDT exam are completed when an enhanced payment is made through a medical chart review. The CONTRACTOR should educate providers to document any barriers to completing all seven components (e.g. past history not available). The enhanced payment rate for the initial EPSDT screening exam shall be ninety-five percent (95%) of the 2001 Medicare fee-schedule. Effective December 1, 2001, the enhanced fee schedule shall be 100% of the 2001 Medicare fee schedule unless otherwise specified by TENNCARE.

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Examination of Normal Newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

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If the BPN-PCP submits a claim with a procedure code for an established patient, the CONTRACTOR may only reimburse the provider at the enhanced payment rate if the claim is for the initial EPSDT exam upon placement in state custody. If the CONTRACTOR directs BPN-PCPs to only bill the initial EPSDT exam with the New Patient procedure code series identified above, the CONTRACTOR must notify and provide appropriate training to the provider and provider's billing staff to implement this billing procedure

2.13.2.2 Case Management

In exchange for performing additional care coordination and case management functions as specified in Section 3 of this Agreement, the CONTRACTOR shall pay Best Practice Network Primary Care Providers a case management fee of \$10 per member per month.

2.13.3 All Covered Services

2.13.3.1 Except as provided in Sections 2.13.2.2 and 2.13.2.3 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.

2.13.3.2 The CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered services for which there is no Medicare reimbursement methodology.

2.13.3.3 As part of a stop-loss arrangement with a provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

2.13.4 Hospice

Hospice services shall be provided and reimbursed in accordance with state and federal requirements, including but not limited to the following:

2.13.4.1 Rates shall be no less than the federally established Medicaid hospice rates (updated each federal fiscal year (FFY)), adjusted by area wage adjustments for the categories described by CMS;

2.13.4.2 The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and

2.13.4.3 If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR shall pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider (not subject to the annual cap for Medicaid Hospice rates).

2.13.5 Behavioral Health Crisis Service Teams

2.13.5.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services. TennCare may require the CONTRACTOR to reimburse crisis mobile teams on a monthly basis at a rate to be determined and set by the State.

2.13.5.2 The CONTRACTOR shall negotiate rates for crisis respite and crisis stabilization services.

2.13.6 Local Health Departments

2.13.6.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.6.3 and 2.12.9) for TENNderCare screenings to members under age twenty-one (21) at the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	\$80.33
99382 New pt. 1- 4 yrs.	\$88.06
99383 New pt. 5 - 11yrs.	\$86.60
99384 New pt. 12 - 17yrs.	\$95.39
99385 New pt. 18 - 39 yrs.	\$93.93
99391 Estab. pt. Up to 1 yr.	\$63.04
99392 Estab. pt. 1 - 4 yrs.	\$71.55
99393 Estab. pt. 5 - 11yrs.	\$70.96
99394 Estab. pt. 12 - 17yrs.	\$79.57
99395 Estab. pt. 18 - 39 yrs.	\$78.99

2.13.6.2 TENNCARE may conduct an audit of the CONTRACTOR's reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is not the required reimbursement rate.

2.13.7 Physician Incentive Plan (PIP)

2.13.7.1 The CONTRACTOR shall notify and make TENNCARE and TDCI aware of any operations or plans to operate a physician incentive plan (PIP). Prior to implementation of any such plans, the CONTRACTOR shall submit to TDCI any provider agreement templates or subcontracts that involve a PIP for review as a material modification.

2.13.7.2 The CONTRACTOR shall not implement a PIP in the absence of TDCI review and written approval.

2.13.7.3 If the CONTRACTOR operates a PIP, the CONTRACTOR shall ensure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.13.7.4 If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR shall report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:

2.13.7.4.1 Whether services not furnished by the physician or physician group are covered by the incentive plan;

2.13.7.4.2 The type or types of incentive arrangements, such as, withholds, bonus, capitation;

2.13.7.4.3 The percent of any withhold or bonus the plan uses;

2.13.7.4.4 Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection; and

2.13.7.4.5 The patient panel size and, if the plan uses pooling, the pooling method.

2.13.8 Emergency Services Obtained from Non-Contract Providers

2.13.8.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section 1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.

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2.13.8.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

2.13.8.3 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section 1 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section 1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.

2.13.9 Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown

2.13.9.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section 2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested. In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

2.13.9.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.10 Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown

2.13.10.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.

2.13.10.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.11 Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider.

2.13.12 Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR

- 2.13.12.1 With the exception of circumstances described in Section 2.13.11, when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.
- 2.13.12.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary.

2.13.13 Covered Services Ordered by Medicare Providers for Dual Eligibles

- 2.13.13.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR shall pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contract provider:
- 2.13.13.1.1 The ordered service requires prior authorization; and
- 2.13.13.1.2 Dually eligible enrollees have been clearly informed of the contract provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and
- 2.13.13.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.
- 2.13.13.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.
- 2.13.13.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

2.13.14 Transition of New Members

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall not deny payment for the costs of continuation of medically necessary covered services provided by contract or non-contract providers for lack of prior authorization or lack of referral during the required time period for continuation of services. However, if, pursuant to Section 2.9.2.1, the CONTRACTOR requires prior authorization for continuation of services beyond thirty (30) calendar days, the CONTRACTOR may deny payment for care rendered beyond the initial thirty (30) days for lack of prior authorization but may not do so solely on the basis that the provider is a non-contract provider.

2.13.15 Transition of Care

In accordance with the requirements in Section 2.9.3.1 of this Agreement, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section 2.9.3.1.

2.13.16 Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR

- 2.13.16.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that is related to the CONTRACTOR than the CONTRACTOR pays to providers and subcontractors that are not related to the CONTRACTOR. For purposes of this

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subsection, "related to" means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the CONTRACTOR, an affiliate (see definition in Section 1 of this Agreement) of the CONTRACTOR, or the CONTRACTOR's management company as well as providers or subcontractors that the CONTRACTOR, an affiliate of the CONTRACTOR or the CONTRACTOR's management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.16.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be considered non-allowable payments for covered services and shall be excluded from medical expenses reported in the Medical Fund Target report required in Section 2.30.14.2.1.

2.13.16.3 As provided in Section 2.30.9 of this Agreement, the CONTRACTOR shall submit information on payments to related providers and subcontractors.

2.13.17 1099 Preparation

In accordance with federal requirements, the CONTRACTOR shall prepare and submit Internal Revenue Service (IRS) Form 1099s for all providers who are not employees of the CONTRACTOR to whom payment is made

2.13.18 Interest

Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

2.13.19 Immediate Eligibility

Medical service payments made in accordance with Section 2.13 shall include payments to providers for services provided during a period of Immediate Eligibility. However, in order to facilitate the invoicing of DCS for services provided to children in state custody who are not TennCare eligible, the CONTRACTOR shall submit to TENNCARE an itemized listing of claims paid on behalf children in state custody for whom Immediate Eligibility was established in accordance with this Agreement and who were not subsequently found to be TennCare eligible, on a monthly basis in the form and format specified in Attachment XIII, Exhibit N.

2.14 UTILIZATION MANAGEMENT (UM)

2.14.1 General

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.2 The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to UM procedures.

2.14.1.3 The UM program shall have criteria that:

2.14.1.3.1 Are objective and based on medical and/or behavioral health evidence;

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- 2.14.1.3.2 Are applied based on individual needs;
- 2.14.1.3.3 Are applied based on an assessment of the local delivery system;
- 2.14.1.3.4 Involve appropriate practitioners in developing, adopting and reviewing them; and
- 2.14.1.3.5 Are annually reviewed and up-dated as appropriate.
- 2.14.1.4 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease.
- 2.14.1.5 Except as provided in Section 2.6.1.4, the CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.
- 2.14.1.6 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.
- 2.14.1.7 The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.
- 2.14.1.8 As part of the provider survey required by Section 2.18.7.3, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.
- 2.14.1.9 Inpatient Care

The CONTRACTOR shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs 2.14.1.9.1 through 2.14.1.9.5 below:
- 2.14.1.9.1 Pre-admission certification process for non-emergency admissions;
- 2.14.1.9.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;
- 2.14.1.9.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of

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medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

2.14.1.9.4 Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and

2.14.1.9.5 Prospective review of same day surgery procedures.

2.14.1.10 Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:

2.14.1.10.1 Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify members with utilization exceeding the threshold defined by TENNCARE in the preceding six (6) month period. The January review shall cover ED utilization during the preceding April through September; the July review shall cover ED utilization during the preceding October through March;

2.14.1.10.2 Enroll members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in MCO case management if appropriate;

2.14.1.10.3 As appropriate, make contact with members whose utilization exceeded the threshold of ED visits defined by TENNCARE in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization; and

2.14.1.10.4 Assess the most likely cause of high utilization and develop an MCO case management plan based on results of the assessment for each member.

2.14.1.11 Hospitalizations and Surgeries

The CONTRACTOR shall comply with any applicable federal and state laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE may conduct special studies to assess the appropriateness of hospital discharges.

2.14.2 **Prior Authorization for Covered Services**

2.14.2.1 General

2.14.2.1.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.1.2 Prior authorization requests shall be reviewed subject to the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request.

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2.14.2.2 Notice of Adverse Action Requirements

2.14.2.2.1 The CONTRACTOR shall clearly document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.

2.14.2.2.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.

2.14.2.3 Medical History Information Requirements

2.14.2.3.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating health care provider(s), as needed, for purposes of making medical necessity determinations. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

2.14.2.3.2 Upon request by TENNCARE, the CONTRACTOR shall provide TENNCARE with individualized medical record information from the treating health care provider(s). The CONTRACTOR shall take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable TennCare rules and regulations, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is decided in favor of the member, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2.14.3 Referrals

2.14.3.1 Except as provided in Section 2.14.4, the CONTRACTOR may require members to seek a referral from their PCP prior to accessing non-emergency specialty physical health services.

2.14.3.2 If the CONTRACTOR requires members to obtain PCP referral, the CONTRACTOR may exempt certain services, identified by the CONTRACTOR in the member handbook, from PCP referral.

2.14.3.3 For members determined to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.

2.14.3.4 The CONTRACTOR shall not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

2.14.3.5 Referral Provider Listing

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

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section 2.17.7.

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- 2.14.3.5.3 As required in Section 2.30.10.6, the CONTRACTOR shall submit to TENNCARE a copy of the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.14.4 Exceptions to Prior Authorization and/or Referrals

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.6.11, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section 1) in accordance with 42 CFR 422.113.

2.14.4.2 TENNderCare

The CONTRACTOR shall not require prior authorization or PCP referral for the provision of TENNderCare screening services.

2.14.4.3 Access to Women's Health Specialists

The CONTRACTOR shall allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

2.14.4.4 Behavioral Health Services

The CONTRACTOR shall not require a PCP referral for members to access a behavioral health provider.

2.14.4.5 Transition of New Members

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements. However, as provided in Section 2.9.2.1, in certain circumstances the CONTRACTOR may require prior authorization for continuation of services beyond the initial thirty (30) days.

2.14.5 PCP Profiling

The CONTRACTOR shall profile its PCPs. Further, the CONTRACTOR shall investigate the circumstances surrounding PCPs who appear to be operating outside peer norms and shall intervene, as appropriate, when utilization or quality of care issues are identified. As part of these profiling activities, the CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back information as requested by TENNCARE. PCP profiling shall include, but not be limited to the following areas:

2.14.5.1 Utilization of Non-Contract Providers

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of services provided by non-contract providers by PCP panel.

2.14.5.2 Specialist Referrals

The CONTRACTOR shall maintain a procedure to identify and evaluate member specialty provider utilization by PCP panel.

2.14.5.3 Emergency Room Utilization

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The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.9.4, members who establish a pattern of accessing emergency room services shall be referred to MCO case management as appropriate for follow-up.

2.14.5.4 Inpatient Admissions

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of inpatient services by PCP panel.

2.14.5.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section 2.9.7 of this Agreement.

2.14.5.6 Advanced Imaging Procedures

The CONTRACTOR shall profile the utilization of advanced imaging procedures by PCP panel. Advanced imaging procedures include: PET Scans; CAT Scans and MRIs.

2.14.5.7 PCP Visits

The CONTRACTOR shall profile the average number of visits per member assigned to each PCP.

2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

2.15.1 Quality Management/Quality Improvement (QM/QI) Program

2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:

2.15.1.1.1 Specifically address behavioral health care;

2.15.1.1.2 Be accountable to the CONTRACTOR's board of directors and executive management team;

2.15.1.1.3 Have substantial involvement of a designated physician and designated behavioral health practitioner;

2.15.1.1.4 Have a QM/QI committee that oversees the QM/QI functions;

2.15.1.1.5 Have an annual work plan;

2.15.1.1.6 Have resources – staffing, data sources and analytical resources – devoted to it; and

2.15.1.1.7 Be evaluated annually and updated as appropriate.

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- 2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.
- 2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.
- 2.15.1.4 Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2 QM/QI Committee

- 2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include staff and contract providers. Medical and behavioral health staff and contract providers shall be represented on the QM/QI committee. This committee shall recommend policy decisions, analyze and evaluate the results of QM/QI activities, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.
- 2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.
- 2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

2.15.3 Performance Improvement Projects (PIPs)

- 2.15.3.1 The CONTRACTOR shall perform two (2) clinical and one (1) non-clinical PIP. The two (2) clinical PIPs shall include one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.
- 2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:
 - 2.15.3.2.1 Rationale for selection as a quality improvement activity;
 - 2.15.3.2.2 Specific population targeted, include sampling methodology if relevant;
 - 2.15.3.2.3 Metrics to determine meaningful improvement and baseline measurement;
 - 2.15.3.2.4 Specific interventions (enrollee and provider);
 - 2.15.3.2.5 Relevant clinical practice guidelines; and
 - 2.15.3.2.6 Date of re-measurement.
- 2.15.3.3 The CONTRACTOR shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR shall identify and implement intervention and

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improvement strategies for achieving the performance goal set for each PIP and ensuring sustained improvements.

2.15.3.4 The CONTRACTOR shall report on PIPs as required in Section 2.30.11.3, Reporting Requirements.

2.15.3.5 After three (3) years, the CONTRACTOR shall, using evaluation criteria established by TENNCARE, determine if one or all of the current PIPs should be continued. If the CONTRACTOR decides to discontinue a PIP, the CONTRACTOR shall identify a new PIP, which must be prior approved by TENNCARE.

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs and shall measure performance against at least two (2) important aspects of each of the guidelines annually as required in Section 2.8. The guidelines shall be reviewed and revised at least every two (2) years or whenever the guidelines change.

2.15.5 NCQA Accreditation

2.15.5.1 The CONTRACTOR shall maintain NCQA accreditation throughout the period of this Agreement.

2.15.5.2 Following accreditation or re-accreditation, the CONTRACTOR must submit a copy of the bound report from NCQA" within 10 days of receipt of the report.

2.15.5.3 Failure to maintain NCQA Accreditation shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 5.2 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from NCQA and may result in termination of this Agreement in accordance with Section 5.2 of this Agreement.

2.15.6 HEDIS and CAHPS

2.15.6.1 Annually, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year.

2.15.6.2 Annually, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year.

2.16 MARKETING

2.16.1 The CONTRACTOR shall not conduct any enrollee marketing activities, as defined in Section 1 of this Agreement. This prohibition includes, but is not limited to the following information and activities:

2.16.1.1 Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services,

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- membership or availability of network providers, and qualifications and skills of network providers.
 - 2.16.1.2 Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;
 - 2.16.1.3 Offers of gifts or material or financial gain as incentives to enroll;
 - 2.16.1.4 Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;
 - 2.16.1.5 Direct solicitation of prospective enrollees;
 - 2.16.1.6 Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;
 - 2.16.1.7 Assertions or statements (whether oral or written) that the enrollee must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits;
 - 2.16.1.8 Assertions or statements (whether written or oral) that the CONTRACTOR is endorsed by CMS, the federal or state government or similar entity;
 - 2.16.1.9 Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions; and
 - 2.16.1.10 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.
- 2.16.2 The prohibition on enrollee marketing shall not apply to health education and outreach activities that are prior approved in writing by TENNCARE. All health education and outreach activities must be prior approved in writing by TENNCARE.
- 2.16.3 The CONTRACTOR shall not use the name of the CONTRACTOR's TennCare MCO in any form of general marketing (as defined in Section 1) without TENNCARE's prior written approval.

2.17 MEMBER MATERIALS

2.17.1 Prior Approval Process for All Member Materials

- 2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials) as well as proposed health education and outreach activities. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, and Section 2.17, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.
- 2.17.1.2 All member materials shall be submitted to TENNCARE on paper and electronic file media, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement shall be submitted for approval; however, unless otherwise requested by TENNCARE, an electronic file for these materials is not required. The electronic files shall be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.

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- 2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.
- 2.17.1.4 Once member materials have been approved in writing by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.
- 2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for written approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.
- 2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

2.17.2 Written Material Guidelines

The CONTRACTOR shall comply with the following requirements as it relates to written member materials:

- 2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;
- 2.17.2.2 All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved in writing by TENNCARE;
- 2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 5.21;
- 2.17.2.4 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:
 - 2.17.2.4.1 The Seal of the State of Tennessee;
 - 2.17.2.4.2 The TennCare name unless the initials "SM" denoting a service mark, is superscripted to the right of the name (TennCaresm);
 - 2.17.2.4.3 The word "free" unless the service is at no cost to all members. If members have cost sharing responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; and
 - 2.17.2.4.4 The use of phrases to encourage enrollment such as "keep your doctor" implying that enrollees can keep all of their physicians. Enrollees in TennCare shall not be led to think that they can continue to go to their current physician, unless that particular physician is a contract provider with the CONTRACTOR's MCO;
- 2.17.2.5 All vital CONTRACTOR documents shall be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR 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;
- 2.17.2.6 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;

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- 2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member; and
- 2.17.2.8 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2.17.3 Distribution of Member Materials

- 2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Agreement. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, and identification cards.
- 2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section 2.17, to members in order to promote health and/or educate enrollees.

2.17.4 Member Handbooks

- 2.17.4.1 The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.
- 2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section 2.4.5 and at least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.
- 2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) shall be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.
- 2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.
- 2.17.4.5 Each member handbook shall, at a minimum, be in accordance with the following guidelines:
 - 2.17.4.5.1 Shall be in accordance with all applicable requirements as described in Section 2.17.2 of this Agreement;
 - 2.17.4.5.2 Shall include a table of contents;
 - 2.17.4.5.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;
 - 2.17.4.5.4 Shall include a description of services provided including benefit limits, exclusions, and use of non-contract providers;
 - 2.17.4.5.5 Shall include descriptions of both the Medicaid Benefits and the Standard Benefits;

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- 2.17.4.5.6 Shall include a description of TennCare cost sharing responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing responsibilities and of their right to appeal in the event that they are billed for amounts other than their TennCare cost sharing responsibilities;
- 2.17.4.5.7 Shall include information about preventive services for adults and children, including TENNderCare, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;
- 2.17.4.5.8 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;
- 2.17.4.5.9 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;
- 2.17.4.5.10 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse line. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse line when they have questions as to whether they should go to the emergency room;
- 2.17.4.5.11 Shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;
- 2.17.4.5.12 Shall include appeal procedures as described in Section 2.19 of this Agreement;
- 2.17.4.5.13 Shall include notice that in addition to the member's right to file an appeal directly to TENNCARE for actions taken by the CONTRACTOR, the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;
- 2.17.4.5.14 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;
- 2.17.4.5.15 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;
- 2.17.4.5.16 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section 2.9.2 of this Agreement;
- 2.17.4.5.17 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;
- 2.17.4.5.18 Shall include notice that a new member may request to change MCOs at anytime during the forty-five (45) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

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- 2.17.4.5.19 Shall include notice that the member may change MCOs at the next choice period as described in Section 2.4.7.2.2 of this Agreement and shall have a forty-five (45) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;
- 2.17.4.5.20 Shall include notice that the member has the right to appeal to TENNCARE to request to change MCOs based on hardship and how to do so;
- 2.17.4.5.21 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;
- 2.17.4.5.22 Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program as well as the service/information that may be obtained from each line;
- 2.17.4.5.23 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
- 2.17.4.5.24 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;
- 2.17.4.5.25 Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section 2.13.7);
- 2.17.4.5.26 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- 2.17.4.5.27 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- 2.17.4.5.28 Shall include information on appropriate prescription drug usage (see Section 2.9.7); and
- 2.17.4.5.29 Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

2.17.5 Quarterly Member Newsletter

- 2.17.5.1 General Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.
- 2.17.5.2 Teen/Adolescent Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.
- 2.17.5.2.1 The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter.

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MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

- 2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.2.1.1.1 Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and
 - 2.17.5.2.1.1.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and
 - 2.17.5.2.1.1.3 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.
- 2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
 - 2.17.5.3.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
 - 2.17.5.3.3 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;
 - 2.17.5.3.4 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;
 - 2.17.5.3.5 Information about appropriate prescription drug usage;
 - 2.17.5.3.6 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and
 - 2.17.5.3.7 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."
- 2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in this Agreement.

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2.17.6 Identification Card

Each member shall be provided an identification card, which identifies the member as a participant in the TennCare program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's MCO or prior to the member's enrollment effective date. The identification card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all state and federal requirements and, at a minimum, shall include:

- 2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;
- 2.17.6.2 Phone numbers for information and/or authorizations, including for behavioral health services;
- 2.17.6.3 Descriptions of procedures to be followed for emergency or special services;
- 2.17.6.4 The member's identification number;
- 2.17.6.5 The member's name (First, Last and Middle Initial);
- 2.17.6.6 The member's date of birth;
- 2.17.6.7 The member's enrollment effective date;
- 2.17.6.8 Copayment information;
- 2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier; and
- 2.17.6.10 The words "Medicaid" or "Standard" based on eligibility.

2.17.7 Provider Directory

- 2.17.7.1 The CONTRACTOR shall distribute provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory shall be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.
- 2.17.7.2 Provider directories, and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.
- 2.17.7.3 Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post-stabilization services, identification of providers accepting new patients and whether or not a provider performs TENNCare screens.

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2.17.8 Additional Information Available Upon Request

The CONTRACTOR shall provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it:

- 2.17.8.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and
- 2.17.8.2 Information regarding physician incentive plans, including but not limited to:
 - 2.17.8.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;
 - 2.17.8.2.2 The type of incentive arrangement; and
 - 2.17.8.2.3 Whether stop-loss protection is provided.

2.18 CUSTOMER SERVICE

2.18.1 Member Services Toll-Free Phone Line

- 2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, comments, and inquiries from the member, the member's family, or the member's provider.
- 2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.
- 2.18.1.3 The member services information line shall handle calls from callers with Limited English Proficiency as well as calls from members who are hearing impaired.
- 2.18.1.4 The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.
- 2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section 2.18.1.
- 2.18.1.6 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, and the CONTRACTOR's provider network.
- 2.18.1.7 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.
- 2.18.1.8 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

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2.18.1.9 Performance Standards for Member Services Line/Queue

2.18.1.9.1 The CONTRACTOR shall adequately staff the member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.1.9.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.

2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language interpreter and translation services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.

2.18.2.2 The CONTRACTOR shall provide interpreter and translation services free of charge to members.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

2.18.3 **Cultural Competency**

As required by 42 CFR 438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

2.18.4 **Provider Services and Toll-Free Telephone Line**

2.18.4.1 The CONTRACTOR shall establish and maintain a provider services function to timely and adequately respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

2.18.4.3 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.4.4 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.

2.18.4.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding prior authorization requests as described in Section 2.14.2 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, prior authorization and referral requirements, and the CONTRACTOR's provider network.

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- 2.18.4.7 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR shall have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 nurse triage line described in Section 2.18.1.5 of this Agreement for this purpose or may use another line the CONTRACTOR designates. The CONTRACTOR shall submit a description of how it will meet the requirements regarding its 24/7 ED assistance line, which shall provide the telephone number that will be used for hospitals requiring scheduling assistance and describe the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line. The CONTRACTOR shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting in accordance with Section 2.30.12.1.3.
- 2.18.4.8 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.
- 2.18.4.9 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.
- 2.18.4.10 Performance Standards for UM Line/Queue
- 2.18.4.10.1 The CONTRACTOR shall adequately staff the provider service line to ensure that the utilization management line/queue meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.
- 2.18.4.10.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.
- 2.18.5 Provider Handbook**
- 2.18.5.1 The CONTRACTOR shall issue a provider handbook to all contract providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider. At a minimum the provider handbook shall include the following information:
- 2.18.5.1.1 Description of the TennCare program;
- 2.18.5.1.2 Covered services;
- 2.18.5.1.3 Emergency service responsibilities;
- 2.18.5.1.4 TENNderCare services and standards;
- 2.18.5.1.5 Information on members' appeal rights;
- 2.18.5.1.6 Policies and procedures of the provider complaint system;
- 2.18.5.1.7 Medical necessity standards and clinical practice guidelines;
- 2.18.5.1.8 PCP responsibilities;

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- 2.18.5.1.9 Coordination with other TennCare contractors or MCO subcontractors;
- 2.18.5.1.10 Prior authorization, referral and other utilization management requirements and procedures;
- 2.18.5.1.11 Protocol for encounter data element reporting/records;
- 2.18.5.1.12 Medical records standard;
- 2.18.5.1.13 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- 2.18.5.1.14 Payment policies;
- 2.18.5.1.15 Member rights and responsibilities;
- 2.18.5.1.16 Important phone numbers of all departments/staff a contract provider may need to reach at the CONTRACTOR's MCO; and
- 2.18.5.1.17 How to reach the provider's assigned provider relations representative.
- 2.18.5.2 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

2.18.6 Provider Education and Training

- 2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Agreement.
- 2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations.
- 2.18.6.3 The CONTRACTOR shall also conduct ongoing provider education and training as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement.
- 2.18.6.4 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.
- 2.18.6.5 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. At least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that provide evidence of compliance with the requirement in this Section 2.18.6.5, including when and how contact is made for each contract provider.

2.18.7 Provider Relations

- 2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to provide ongoing troubleshooting and education for contract providers.
- 2.18.7.2 The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Agreement.
- 2.18.7.3 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, and provider education,

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provider complaints, claims processing, claims reimbursement and utilization management processes, including medical reviews. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

2.18.8 Provider Complaint System

2.18.8.1 The CONTRACTOR shall establish and maintain a provider complaint system for any provider (contract or non-contract) who is not satisfied with the CONTRACTOR's policies and procedures or a decision made by the CONTRACTOR that does not impact the provision of services to members.

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-126(b).

2.18.9 Member Involvement with Behavioral Health Services

2.18.9.1 The CONTRACTOR shall develop policies and procedures with respect to member, parent, or legally appointed representative involvement with behavioral health. These policies and procedures shall include, at a minimum, the following elements:

2.18.9.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

2.18.9.1.2 The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

2.18.9.1.3 The requirement that provider education include materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirement will be met; and

2.18.9.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative involvement in behavioral health treatment planning.

2.18.9.2 The CONTRACTOR shall provide an education plan for all members with behavioral health issues; education shall occur on a regular basis. At a minimum, educational materials shall include information on medications and their side effects; behavioral health disorders and treatment options; self-help groups, peer support, and other community support services available for members and families.

2.18.9.3 The CONTRACTOR shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s) or legally appointed representative, and adults for whom voluntary inpatient treatment is being considered, of all their options for residential and/or inpatient placement, and alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

2.18.9.4 The CONTRACTOR shall require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

2.19 COMPLAINTS AND APPEALS

2.19.1 General

- 2.19.1.1 Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2.17.4. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.
- 2.19.1.2 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2.15.2, to the review of member complaints and appeals that have been received.
- 2.19.1.3 The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2.19.2 Appeals

- 2.19.2.1 The CONTRACTOR's appeal process shall, at a minimum, meet the requirements outlined herein.
- 2.19.2.2 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.
- 2.19.2.3 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
- 2.19.2.4 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action shall be taken by the CONTRACTOR regarding the handling and disposition of an appeal.
- 2.19.2.5 The CONTRACTOR shall identify the appropriate individual or body within the CONTRACTOR's MCO having decision-making authority as part of the appeal procedure.
- 2.19.2.6 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

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- 2.19.2.7 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).
- 2.19.2.8 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.
- 2.19.2.9 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the member and TENNCARE.
- 2.19.2.10 The CONTRACTOR shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.
- 2.19.2.11 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.
- 2.19.2.12 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.
- 2.19.2.13 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
- 2.19.2.14 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- 2.19.2.15 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.
- 2.19.2.16 The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2.24.4.
- 2.19.2.17 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.19.2.18 Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and copayment responsibilities shall be directed to the Department of Human Services.

2.20 FRAUD AND ABUSE

2.20.1 General

- 2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.
- 2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.
- 2.20.1.3 The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.
- 2.20.1.4 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

2.20.2 Reporting and Investigating Suspected Fraud and Abuse

- 2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement. The CONTRACTOR shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:
 - 2.20.2.1.1 Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG;
 - 2.20.2.1.2 All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU; and
 - 2.20.2.1.3 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG;
- 2.20.2.2 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment X, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Agreement.
- 2.20.2.3 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to OIG or TBI MFCU, as appropriate.
- 2.20.2.4 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:
 - 2.20.2.4.1 Contact the subject of the investigation about any matters related to the investigation;
 - 2.20.2.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - 2.20.2.4.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

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- 2.20.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
- 2.20.2.6 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- 2.20.2.7 The State shall not transfer its law enforcement functions to the CONTRACTOR.
- 2.20.2.8 The CONTRACTOR and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.
- 2.20.2.9 The CONTRACTOR shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.
- 2.20.2.10 Except as described in Section 2.11.7.2 of this Agreement, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.

2.20.3 Compliance Plan

- 2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Agreement execution and annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request.
- 2.20.3.2 The CONTRACTOR's fraud and abuse compliance plan shall:
 - 2.20.3.2.1 Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Agreement;
 - 2.20.3.2.2 Ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
 - 2.20.3.2.3 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Agreement; and
 - 2.20.3.2.4 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
 - 2.20.3.2.4.1 Claims edits;
 - 2.20.3.2.4.2 Post-processing review of claims;

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- 2.20.3.2.4.3 Provider profiling and credentialing;
- 2.20.3.2.4.4 Prior authorization;
- 2.20.3.2.4.5 Utilization management;
- 2.20.3.2.4.6 Relevant subcontractor and provider agreement provisions; and
- 2.20.3.2.4.7 Written provider and member material regarding fraud and abuse referrals.
- 2.20.3.2.5 Contain provisions for the confidential reporting of plan violations to the designated person;
- 2.20.3.2.6 Contain provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;
- 2.20.3.2.7 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;
- 2.20.3.2.8 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
- 2.20.3.2.9 Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG; and
- 2.20.3.2.10 Ensure that no individual who reports MCO violations or suspected fraud and abuse is retaliated against.
- 2.20.3.3 The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.
- 2.20.3.4 The CONTRACTOR shall report fraud and abuse activities as required in Section 2.30.13, Reporting Requirements.

2.21 FINANCIAL MANAGEMENT

The CONTRACTOR shall be responsible for sound financial management of its MCO. The CONTRACTOR shall adhere to the minimum guidelines outlined below.

2.21.1 Administrative Payments

The CONTRACTOR shall accept administrative fee payments, premium tax payments, and incentive payments, if applicable, remitted by TENNCARE in accordance with Section 4.

2.21.2 Savings/Loss

2.21.2.1 The CONTRACTOR shall not be required to share with TENNCARE any financial gains realized under this Agreement.

2.21.2.2 TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

2.21.3 Interest

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion.

2.21.4 Third Party Liability Resources

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- 2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party.
- 2.21.4.1.1 If third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.
- 2.21.4.1.2 If TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.
- 2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for one of these services:
 - 2.21.4.1.3.1 TENNderCare;
 - 2.21.4.1.3.2 Prenatal or preventive pediatric care; or
 - 2.21.4.1.3.3 All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.
- 2.21.4.1.4 The claims specified in Sections 2.21.4.1.3.1, 2.21.4.1.3.2, and 2.21.4.1.3.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.
- 2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.
- 2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2.21.4 of this Agreement
- 2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee.
- 2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State.
- 2.21.4.6 The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation claims. This editing should, at minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
- 2.21.4.7 TennCare cost sharing responsibilities permitted pursuant to Section 2.6.15 of this Agreement shall not be considered TPL.
- 2.21.4.8 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.

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- 2.21.4.9 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.
- 2.21.4.10 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.
- 2.21.4.11 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.
- 2.21.4.12 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.21.5 Solvency Requirements

2.21.5.1 Minimum Net Worth

- 2.21.5.1.1 The CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-112.
- 2.21.5.1.2 Any and all payments made by TENNCARE, including administrative fee payments, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-112.
- 2.21.5.1.3 The CONTRACTOR shall demonstrate evidence of its compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR.

2.21.5.2 Restricted Deposits

The CONTRACTOR shall achieve and maintain restricted deposits in an amount equal to the net worth requirement specified in Section 2.21.5.1. TDCI shall calculate the amount of restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement.

2.21.5.3 Liquidity Ratio Requirement

In addition to the positive working capital requirement described in TCA 56-32-112, the CONTRACTOR shall maintain a liquidity ratio where admitted assets consisting of cash, cash equivalents, short-term investments and bonds exceed total liabilities as reported on the NAIC financial statements.

- 2.21.5.4 If the CONTRACTOR fails to meet and/or maintain the applicable net worth and/or restricted deposit financial requirements in accordance with Sections 2.21.5.1 through 2.21.5.3, as determined by TDCI, the CONTRACTOR agrees that said failure shall constitute hazardous financial conditions as defined by TCA 56-32-112 and the CONTRACTOR shall be considered to be in breach of the terms of the Agreement.

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2.21.6 Accounting Requirements

- 2.21.6.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.
- 2.21.6.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in this Agreement.

2.21.7 Insurance

- 2.21.7.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Agreement. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.
- 2.21.7.2 The CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.
- 2.21.7.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.
- 2.21.7.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.
- 2.21.7.5 Failure to provide proof of adequate coverage within the specified time period may result in this Agreement being terminated.

2.21.8 Ownership and Financial Disclosure

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made in accordance with the requirements in Section 2.30.14.2. The following information shall be disclosed:

- 2.21.8.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;
- 2.21.8.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;

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- 2.21.8.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;
- 2.21.8.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;
- 2.21.8.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:
 - 2.21.8.5.1 The CONTRACTOR shall disclose the following transactions:
 - 2.21.8.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;
 - 2.21.8.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and
 - 2.21.8.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 - 2.21.8.5.2 The information which shall be disclosed in the transactions includes:
 - 2.21.8.5.2.1 The name of the party in interest for each transaction;
 - 2.21.8.5.2.2 A description of each transaction and the quantity or units involved;
 - 2.21.8.5.2.3 The accrued dollar value of each transaction during the fiscal year; and
 - 2.21.8.5.2.4 Justification of the reasonableness of each transaction.
 - 2.21.8.5.3 If the Agreement is being renewed or extended, the CONTRACTOR shall disclose information on business transactions which occurred during the prior contract period. If the Agreement is an initial Agreement with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions shall be reported.
 - 2.21.8.5.4 A party in interest is:
 - 2.21.8.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
 - 2.21.8.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
 - 2.21.8.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or

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- 2.21.8.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.8.5.4.1, 2.21.8.5.4.2, or 2.21.8.5.4.3
- 2.21.8.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

2.21.9 Internal Audit Function

The CONTRACTOR shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The CONTRACTOR's internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section 2.22.6 of this Agreement.

2.21.10 Audit of Business Transactions

- 2.21.10.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the requirements in Section 2.30.14.3.5 of this Agreement.
- 2.21.10.2 No later than December 1 of each year, the CONTRACTOR shall submit a copy of the full executed agreement to audit accounts to TENNCARE. Such agreement shall include the following language:
 - 2.21.10.2.1 The auditor agrees to retain working papers for no less than five (5) years and that all audit working papers shall, upon request, be made available for review by the Comptroller of the Treasury, the Comptroller's representatives, agents, and legal counsel, or the TennCare Division of the Tennessee Department of Commerce and Insurance, during normal working hours while the audit is in progress and/or subsequent to the completion of the report. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section 2.23.2 (Data and Document Management Requirements), 2.23.3 (System and Data Integration Requirements), or 2.23.6 (Security and Access Management Requirements) of this Agreement.
 - 2.21.10.2.2 Any evidence of fraud, such as defalcation, misappropriation, misfeasance, malfeasance, embezzlement, fraud or other illegal acts shall be reported by the auditor, in writing immediately upon discovery, to the Comptroller of the Treasury, State of Tennessee, who shall under all circumstances have the authority, at the discretion of the Comptroller, to directly investigate such matters. If the circumstances disclosed by the audit call for a more detailed investigation by the auditor than necessary under ordinary circumstances, the auditor shall inform the organization's governing body in writing of the need for such additional investigation and the additional compensation required therefor. Upon approval by the Comptroller of the Treasury, an amendment to this contract may be made by the organization's governing body and the auditor for such additional investigation.

2.22 CLAIMS MANAGEMENT

2.22.1 General

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, and compliance with all applicable state and federal laws, rules and regulations.

2.22.2 Claims Management System Capabilities

- 2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service, date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track service use against hard benefit limits in accordance with a methodology set by TENNCARE.
- 2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.).
- 2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section 2.23 of this Agreement.
- 2.22.2.4 As part of this ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.
- 2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
- 2.22.2.6 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

2.22.3 Paper Based Claims Formats

- 2.22.3.1 The CONTRACTOR shall comply at all times with standardized paper billing forms/formats (and all future updates) as follows:

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450
Dental	ADA

- 2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.
- 2.22.3.3 For the forms identified in Section 2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.
- 2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

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2.22.4 Prompt Payment

- 2.22.4.1 The CONTRACTOR shall comply with prompt pay claims processing requirements in accordance with TCA 56-32-126.
- 2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.
- 2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for covered services delivered to a TennCare enrollee. The terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-126(b)(1)(A) and (B).
- 2.22.4.4 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.
- 2.22.4.5 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.
- 2.22.4.6 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR's MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment.
- 2.22.4.7 As it relates to MCO Assignment Unknown (see Sections 2.13.9 and 2.13.10), the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.22.5 Claims Dispute Management

- 2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved in writing by TENNCARE prior to its implementation.
- 2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-126.
- 2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

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2.22.6 Claims Payment Accuracy – Minimum Audit Procedures

- 2.22.6.1 On a monthly basis the CONTRACTOR shall submit claims payment accuracy percentage reports (see Section 2.30.15).
- 2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section 2.21.9 of this Agreement.
- 2.22.6.3 The audit shall utilize a random sample of all “processed or paid” claims upon initial submission in each month (the terms “processed and paid” are synonymous with terms “process and pay” of TCA 56-32-126(b)(1)(A) and (B)). A minimum sample of one-hundred (100) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required.
- 2.22.6.4 The minimum attributes to be tested for each claim selected shall include:
 - 2.22.6.4.1 Claim data correctly entered into the claims processing system;
 - 2.22.6.4.2 Claim is associated to the correct provider;
 - 2.22.6.4.3 Service obtained the proper authorization;
 - 2.22.6.4.4 Member eligibility at processing date correctly applied;
 - 2.22.6.4.5 Allowed payment amount agrees with contracted rate;
 - 2.22.6.4.6 Duplicate payment of the same claim has not occurred;
 - 2.22.6.4.7 Denial reason applied appropriately;
 - 2.22.6.4.8 Copayment application considered and applied;
 - 2.22.6.4.9 Effect of modifier codes correctly applied;
 - 2.22.6.4.10 Processing considered if service subject to hard benefit limits considered and applied;
 - 2.22.6.4.11 Other insurance properly considered and applied;
 - 2.22.6.4.12 Application of hard benefit limits; and
 - 2.22.6.4.13 Proper coding including bundling/unbundling.
- 2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:
 - 2.22.6.5.1 Results for each attribute tested for each claim selected;
 - 2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;
 - 2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;
 - 2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and
 - 2.22.6.5.5 Claims processed or paid in error have been corrected.

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- 2.22.6.6 If the CONTRACTOR subcontracts for the provision of any covered services (see Section 2.26), and the subcontractor is responsible for processing claims (see Section 2.26.10), then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report shall be based on an audit conducted in compliance with the requirements of this Section 2.22.6.

2.22.7 Claims Processing Methodology Requirements

- 2.22.7.1 The CONTRACTOR shall perform front end system edits, including but not limited to:
 - 2.22.7.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;
 - 2.22.7.1.2 Third party liability (TPL);
 - 2.22.7.1.3 Medical necessity (e.g., appropriate age/sex for procedure);
 - 2.22.7.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;
 - 2.22.7.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;
 - 2.22.7.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;
 - 2.22.7.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted;
 - 2.22.7.1.8 Quantity of service: the system shall evaluate claims for services provided to members to ensure that any applicable hard benefit limits are applied; and
 - 2.22.7.1.9 Benefit limits: the system shall ensure that hard benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid.
- 2.22.7.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., not in the future or outside of a member's TennCare eligibility span.
- 2.22.7.3 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary.
- 2.22.7.4 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

2.22.8 Explanation of Benefits (EOBs) and Related Functions

- 2.22.8.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.
- 2.22.8.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.
- 2.22.8.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall

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include: claims for services with hard benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

2.22.8.4 Regarding the paid claims sample referenced in Section 2.22.6.3, the CONTRACTOR shall stratify said sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CONTRACTOR considers a particular specialty (or provider) to warrant closer scrutiny, the CONTRACTOR may over sample the group. The paid claims sample should be a minimum of twenty-five (25) claims per check run with a minimum of 100 claims per month.

2.22.8.5 Based on the EOBs sent to TennCare enrollees, the CONTRACTOR shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The CONTRACTOR shall use the feedback received to modify or enhance the EOB sampling methodology.

2.22.9 Remittance Advices and Related Functions

2.22.9.1 In concert with its claims payment cycle the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the CONTRACTOR.

2.22.9.2 The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.

2.22.9.3 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

2.22.9.4 In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

2.22.10 Processing of Payment Errors

The CONTRACTOR shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from TENNCARE.

2.22.11 Notification to Providers

For purposes of network management, the CONTRACTOR shall, at a minimum, notify all contract providers to file claims associated with covered services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

2.22.12 Payment Cycle

At a minimum, the CONTRACTOR shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CONTRACTOR and approved in writing by TENNCARE.

2.22.13 Excluded Providers

2.22.13.1 The CONTRACTOR shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with TENNCARE.

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- 2.22.13.2 The CONTRACTOR shall not pay any claim submitted by a provider that is on payment hold under the authority of TENNCARE.

2.23 INFORMATION SYSTEMS

2.23.1 General Provisions

2.23.1.1 Systems Functions

The CONTRACTOR shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet TENNCARE and federal reporting requirements and other Agreement requirements and that are in compliance with this Agreement and all applicable state and federal laws, rules and regulations including HIPAA.

2.23.1.2 Systems Capacity

The CONTRACTOR's Systems shall possess capacity sufficient to handle the workload projected for the start date of operations and shall be scaleable and flexible so they can be adapted as needed, within negotiated time frames, in response to changes in Agreement requirements, increases in enrollment estimates, etc.

2.23.1.3 Electronic Messaging

- 2.23.1.3.1 The CONTRACTOR shall provide a continuously available electronic mail communication link (e-mail system) with TENNCARE.

- 2.23.1.3.2 The e-mail system shall be capable of attaching and sending documents created using software products other than CONTRACTOR's Systems, including TENNCARE's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

- 2.23.1.3.3 As needed, the CONTRACTOR shall be able to communicate with TENNCARE using TENNCARE's e-mail system over a secure virtual private network (VPN).

- 2.23.1.3.4 As needed, based on the sensitivity of data contained in an electronic message, the CONTRACTOR shall support network-to-network encryption of said messages.

2.23.1.4 Participation in Information Systems Work Groups/Committees

The CONTRACTOR and TENNCARE shall establish an information systems work group/committee to coordinate activities and develop cohesive systems strategies among TENNCARE and the MCOs. The Work Group will meet on a designated schedule as agreed to by TENNCARE and the CONTRACTOR.

2.23.1.5 Connectivity to TENNCARE/State Network and Systems

The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

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2.23.1.6 Systems Refresh Plan

The CONTRACTOR shall provide to TENNCARE an annual Systems refresh plan (see Section 2.30.16). The plan shall outline how Systems within the CONTRACTOR's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan shall also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

2.23.2 **Data and Document Management Requirements**

2.23.2.1 Adherence to Data and Document Management Standards

2.23.2.1.1 The CONTRACTOR's Systems shall conform to the data and document management standards by information type/subtype detailed in the HIPAA Implementation and TennCare Companion guides, inclusive of the standard transaction code sets specified in the guides.

2.23.2.1.2 The CONTRACTOR's Systems shall conform to HIPAA standards for data and document management that are currently under development within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE.

2.23.2.2 Data Model and Accessibility

The CONTRACTOR's Systems shall be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant; alternatively, the CONTRACTOR's Systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain said databases.

2.23.2.3 Data and Document Relationships

2.23.2.3.1 When the CONTRACTOR houses indexed images of documents used by members and providers to transact with the CONTRACTOR the CONTRACTOR shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider identification number.

2.23.2.3.2 The CONTRACTOR shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about a reported problem.

2.23.2.3.3 Upon TENNCARE request, the CONTRACTOR shall be able to generate a listing of all members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The CONTRACTOR shall also be able to generate a sample of said document.

2.23.2.4 Information Retention

2.23.2.4.1 The CONTRACTOR shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements. The plan shall comply with the applicable requirements of the Tennessee Department of General Services, Records Management Division.

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- 2.23.2.4.2 The CONTRACTOR shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.
- 2.23.2.4.3 The CONTRACTOR shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.
- 2.23.2.4.4 If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.23.2.5 Information Ownership

All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Agreement is owned by TENNCARE. The CONTRACTOR is expressly prohibited from sharing or publishing TENNCARE information and reports without the prior written consent of TENNCARE.

2.23.3 **System and Data Integration Requirements**

2.23.3.1 Adherence to Standards for Data Exchange

2.23.3.1.1 The CONTRACTOR's Systems shall be able to transmit, receive and process data in HIPAA-compliant or TENNCARE-specific formats and methods, including but not limited to secure File Transfer Protocol (FTP) over a secure connection such as a VPN, that are in use at the start of Systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

2.23.3.1.2 The CONTRACTOR's Systems shall conform to future federal and/or TENNCARE specific standards for data exchange within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE. The CONTRACTOR shall partner with TENNCARE in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

2.23.3.2 HIPAA Compliance Checker

All HIPAA-conforming exchanges of data between TENNCARE and the CONTRACTOR shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

2.23.3.3 TENNCARE/State Website/Portal Integration

Where deemed that the CONTRACTOR's Web presence will be incorporated to any degree to TENNCARE's or the state's web presence/portal, the CONTRACTOR shall conform to the applicable TENNCARE or state standards for website structure, coding and presentation.

2.23.3.4 Connectivity to and Compatibility/Interoperability with TENNCARE Systems and IS Infrastructure

2.23.3.4.1 The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

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2.23.3.4.2 All of the CONTRACTOR's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with TENNCARE and/or state systems and shall conform to applicable standards and specifications set by TENNCARE and/or the state agency that owns the system.

2.23.3.5 Data Exchange in Support of TENNCARE's Program Integrity and Compliance Functions

The CONTRACTOR's System(s) shall be capable of generating files in the prescribed formats for upload into TENNCARE Systems used specifically for program integrity and compliance purposes.

2.23.3.6 Address Standardization

The CONTRACTOR's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

2.23.4 **Encounter Data Provision Requirements (Encounter Submission and Processing)**

2.23.4.1 Adherence to HIPAA Standards

The CONTRACTOR's Systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

2.23.4.2 Quality of Submission

2.23.4.2.1 The CONTRACTOR shall submit encounter data that meets established TENNCARE data quality standards. These standards are defined by TENNCARE to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TENNCARE will revise and amend these standards as necessary to ensure continuous quality improvement. The CONTRACTOR shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with TENNCARE data quality standards as originally defined or subsequently amended. The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the CONTRACTOR denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the CONTRACTOR shall submit all available claim data to TENNCARE without alteration or omission. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR shall require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims (see Section 2.12.7.31); the CONTRACTOR shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TENNCARE, in order to support comprehensive financial reporting and utilization analysis. The CONTRACTOR shall submit encounter data according to standards and formats as defined by TENNCARE, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Due to the need for timely data and to maintain integrity of processing sequence, the CONTRACTOR shall address any issues that prevent processing of an encounter batch in accordance with procedures specified in Section 2.23.13.

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- 2.23.4.2.2 TENNCARE will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by TENNCARE to ensure accurate processing or encounter data quality, and will return these transactions to the CONTRACTOR for research and resolution. TENNCARE will require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats, in accordance with the procedure specified in Section 2.23.13. Generally the CONTRACTOR shall, unless otherwise directed by TENNCARE, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. TENNCARE may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section 2.23.13.
- 2.23.4.3 Provision of Encounter Data
- 2.23.4.3.1 Within two (2) business days of the end of a payment cycle the CONTRACTOR shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.
- 2.23.4.3.2 Any encounter data from a subcontractor shall be included in the file from the CONTRACTOR. The CONTRACTOR shall not submit separate encounter files from subcontractors.
- 2.23.4.3.3 The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CONTRACTOR has a capitation arrangement.
- 2.23.4.3.4 The level of detail associated with encounters from providers with whom the CONTRACTOR has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CONTRACTOR received and settled a fee-for-service claim.
- 2.23.4.3.5 The CONTRACTOR shall adhere to federal and/or TENNCARE payment rules in the definition and treatment of certain data elements, e.g., units of service, that are standard fields in the encounter data submissions and will be treated similarly by TENNCARE across all MCOs.
- 2.23.4.3.6 The CONTRACTOR shall provide encounter data files electronically to TENNCARE in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.
- 2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio reports and supply the reconciliation to TENNCARE with each of the Medical Loss Ratio report submissions as specified in Section 2.30.14.2.1.

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- 2.23.4.3.8 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CONTRACTOR's applicable reimbursement methodology for that service.
- 2.23.4.3.9 The CONTRACTOR shall be able to receive, maintain and utilize data extracts from TENNCARE and its contractors, e.g., pharmacy data from TENNCARE or its PBM.

2.23.5 Eligibility and Enrollment Data Exchange Requirements

- 2.23.5.1 The CONTRACTOR shall receive, process and update enrollment files sent daily by TENNCARE.
- 2.23.5.2 The CONTRACTOR shall update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.
- 2.23.5.3 The CONTRACTOR shall transmit to TENNCARE, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides or as otherwise specified by TENNCARE: member address changes, telephone number changes, and PCP.
- 2.23.5.4 The CONTRACTOR shall be capable of uniquely identifying a distinct TennCare member across multiple populations and Systems within its span of control.
- 2.23.5.5 The CONTRACTOR shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TENNCARE, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

2.23.6 System and Information Security and Access Management Requirements

- 2.23.6.1 The CONTRACTOR's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:
 - 2.23.6.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;
 - 2.23.6.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by TENNCARE and the CONTRACTOR; and
 - 2.23.6.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.
- 2.23.6.2 The CONTRACTOR shall make System information available to duly authorized representatives of TENNCARE and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.
- 2.23.6.3 The CONTRACTOR's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CONTRACTOR and TENNCARE.
- 2.23.6.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:
 - 2.23.6.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

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- 2.23.6.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;
- 2.23.6.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;
- 2.23.6.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;
- 2.23.6.4.5 Facilitate auditing of individual records as well as batch audits; and
- 2.23.6.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within 48 hours.
- 2.23.6.5 The CONTRACTOR's Systems shall have inherent functionality that prevents the alteration of finalized records.
- 2.23.6.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CONTRACTOR shall provide TENNCARE with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.
- 2.23.6.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.
- 2.23.6.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.
- 2.23.6.9 The CONTRACTOR shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR's span of control. This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.
- 2.23.6.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved in writing by TENNCARE.
- 2.23.6.11 The CONTRACTOR shall comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate federal agencies.

2.23.7 Systems Availability, Performance and Problem Management Requirements

- 2.23.7.1 The CONTRACTOR shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to Confirmation of MCO Enrollment (CME), ECM, and self-service customer service functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by TENNCARE and the CONTRACTOR. Unavailability caused by events outside of a CONTRACTOR's span of control is outside of the scope of this requirement.
- 2.23.7.2 The CONTRACTOR shall ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday.

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- 2.23.7.3 The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with TENNCARE are available and operational according to specifications and the data exchange schedule.
- 2.23.7.4 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.
- 2.23.7.5 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and the availability of critical information as defined in this Section of the Agreement, including any problems impacting scheduled exchanges of data between the CONTRACTOR and TENNCARE, the CONTRACTOR shall notify the applicable TennCare staff via phone, fax and/or electronic mail within sixty (60) minutes of such discovery. In its notification the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes.
- 2.23.7.6 Where the problem results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, the CONTRACTOR shall notify the applicable TENNCARE staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.
- 2.23.7.7 The CONTRACTOR shall provide to appropriate TENNCARE staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.
- 2.23.7.8 The CONTRACTOR shall resolve unscheduled System unavailability of CME and ECM functions, caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control, and shall implement the restoration of services, within sixty (60) minutes of the official declaration of System unavailability. Unscheduled System unavailability to all other CONTRACTOR System functions caused by systems and telecommunications technologies within the CONTRACTOR's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.
- 2.23.7.9 Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CONTRACTOR's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period.
- 2.23.7.10 The CONTRACTOR shall not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CONTRACTOR's span of control.
- 2.23.7.11 Within five (5) business days of the occurrence of a problem with system availability, the CONTRACTOR shall provide TENNCARE with full written documentation that includes a corrective action plan describing how the CONTRACTOR will prevent the problem from occurring again.
- 2.23.7.12 Business Continuity and Disaster Recovery (BC-DR) Plan
- 2.23.7.12.1 Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved in writing by TENNCARE.
- 2.23.7.12.2 At a minimum the CONTRACTOR's BC-DR plan shall address the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational

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errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

- 2.23.7.12.3 The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.
- 2.23.7.12.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions per the standards outlined elsewhere in this Section, Section 2.23 of the Agreement.
- 2.23.7.12.5 The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 2.30.16.

2.23.8 System User and Technical Support Requirements

- 2.23.8.1 The CONTRACTOR shall provide Systems Help Desk (SHD) services to all TENNCARE staff and the other agencies that may have direct access to CONTRACTOR systems.
- 2.23.8.2 The CONTRACTOR's SHD shall be available via local and toll-free telephone service and via e-mail from 7 a.m. to 7 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, with the exception of State of Tennessee holidays. Upon TENNCARE request, the CONTRACTOR shall staff the SHD on a state holiday, Saturday, or Sunday.
- 2.23.8.3 The CONTRACTOR's SHD staff shall answer user questions regarding CONTRACTOR System functions and capabilities; report recurring programmatic and operational problems to appropriate CONTRACTOR or TENNCARE staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate TENNCARE login account administrator.
- 2.23.8.4 The CONTRACTOR shall ensure individuals who place calls to the SHD between the hours of 7 p.m. and 7 a.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), shall be able to leave a message. The CONTRACTOR's SHD shall respond to messages by noon the following business day.
- 2.23.8.5 The CONTRACTOR shall ensure recurring problems not specific to System unavailability identified by the SHD shall be documented and reported to CONTRACTOR management within one (1) business day of recognition so that deficiencies are promptly corrected.
- 2.23.8.6 The CONTRACTOR shall have an IS service management system that provides an automated method to record, track and report on all questions and/or problems reported to the SHD.

2.23.9 System Testing and Change Management Requirements

- 2.23.9.1 The CONTRACTOR shall notify the applicable TENNCARE staff person of the following changes to Systems within its span of control within at least ninety (90) calendar days of the projected date of the change.

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- 2.23.9.1.1 Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, and encounter data management; and
- 2.23.9.1.2 Conversions of core transaction management Systems.
- 2.23.9.2 If so directed by TENNCARE, the CONTRACTOR shall discuss the proposed change in the Systems work group.
- 2.23.9.3 The CONTRACTOR shall respond to TENNCARE notification of System problems not resulting in System unavailability according to the following time frames:
 - 2.23.9.3.1 Within five (5) calendar days of receiving notification from TENNCARE the CONTRACTOR shall respond in writing to notices of system problems.
 - 2.23.9.3.2 Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
 - 2.23.9.3.3 The CONTRACTOR shall correct the deficiency by an effective date to be determined by TENNCARE.
 - 2.23.9.3.4 The CONTRACTOR's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.
 - 2.23.9.3.5 The CONTRACTOR shall put in place procedures and measures for safeguarding against unauthorized modifications to CONTRACTOR Systems.
- 2.23.9.4 Valid Window for Certain System Changes

Unless otherwise agreed to in advance by TENNCARE as part of the activities described in this Section 2.23.9, the CONTRACTOR shall not schedule System unavailability to perform System maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.
- 2.23.9.5 Testing
 - 2.23.9.5.1 The CONTRACTOR shall work with TENNCARE pertaining to any testing initiative as required by TENNCARE.

2.23.10 Information Systems Documentation Requirements

- 2.23.10.1 The CONTRACTOR shall ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
- 2.23.10.2 The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute to TENNCARE distinct System design and management manuals, user manuals and quick/reference guides, and any updates.
- 2.23.10.3 The CONTRACTOR's System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.
- 2.23.10.4 When a System change is subject to TENNCARE prior written approval, the CONTRACTOR shall submit revisions to the appropriate manuals for prior written approval before implementing said System changes.

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2.23.10.5 All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals shall be published in accordance to the appropriate TENNCARE and/or TENNCARE standard.

2.23.10.6 The CONTRACTOR shall update the electronic version of these manuals immediately; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

2.23.11 Reporting Requirements (Specific to Information Management and Systems Functions and Capabilities)

2.23.11.1 The CONTRACTOR shall comply with all reporting requirements as described in Section 2.30.16 of this Agreement.

2.23.11.2 The CONTRACTOR shall provide systems-based capabilities for access by authorized TENNCARE personnel, on a secure and read-only basis, to data that can be used in ad hoc reports.

2.23.12 Other Requirements

2.23.12.1 Statewide Data Warehouse Requirements

The CONTRACTOR shall participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but not be limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each MCO.

2.23.12.2 Community Health Record for TennCare Enrollees (Electronic Medical Record)

2.23.12.2.1 At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable time frame, a secure, Web-accessible community health record for TennCare enrollees.

2.23.12.2.2 The design of the Web site for accessing the community health record and the record format and design shall comply with HIPAA, other federal and all state privacy and confidentiality regulations.

2.23.12.2.3 The CONTRACTOR shall provide a Web-based access vehicle for contract providers to the System described in Section 2.23.12.2.1, and shall work with said providers to encourage adoption of this System.

2.23.13 Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems

2.23.13.1 Within five (5) business days of receipt of notice from TENNCARE of the occurrence of a problem with the provision and/or intake of an encounter or enrollment file, the CONTRACTOR shall provide TENNCARE with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the CONTRACTOR has addressed or will address the immediate problem and how the CONTRACTOR shall prevent the problem from recurring. In the event that the CONTRACTOR fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TENNCARE, fails to submit a corrective action plan as requested or required, or fails to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 5.8. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions or be considered a breach of the Agreement.

2.23.13.2 Individual records submitted by the CONTRACTOR may be rejected; these records, once errors therein have been corrected, shall be resubmitted by the CONTRACTOR as stipulated by TENNCARE. In the event that the CONTRACTOR is unable to research or address

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reported errors in a timely manner as required by TENNCARE, the CONTRACTOR shall submit to TENNCARE a corrective action plan describing how the CONTRACTOR will research and address the errors and how the CONTRACTOR shall prevent the problem from recurring within five (5) business days of receipt of notice from TENNCARE that individual records submitted by the CONTRACTOR have been rejected. In the event that the CONTRACTOR fails to address or resolve problems with individual records in a timely manner as required by TENNCARE, which shall include failure to submit a corrective action plan as requested or required, or failure to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 5.8. Continued or repeated failure to address reported errors may result in additional damages or sanctions or be considered a breach of the Agreement.

2.23.13.3 In the event that the CONTRACTOR fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Agreement, the CONTRACTOR shall submit to TENNCARE a corrective action plan that describes how the failure will be resolved. The corrective action plan shall be delivered within five (5) business days of the conclusion of the test.

2.24 ADMINISTRATIVE REQUIREMENTS

2.24.1 General Responsibilities

2.24.1.1 TENNCARE shall be responsible for management of this Agreement. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 USC 1396a(a)(19).

2.24.1.2 The CONTRACTOR shall be responsible for complying with the requirements of this Agreement and shall act in good faith in the performance of the requirements of this Agreement.

2.24.1.3 The CONTRACTOR shall develop policies and procedures that describe, in detail, how the CONTRACTOR will comply with the requirements of this Agreement and, as applicable, are specific to the Grand Region covered by this Agreement, and the CONTRACTOR shall administer this Agreement in accordance with those policies and procedures unless otherwise directed or approved in writing by TENNCARE.

2.24.1.4 It is recognized that TennCare Select medical management procedures may differ from the CONTRACTOR's medical management procedures utilized for operations under the "TennCare Contractor Risk Agreement" in order to recognize the unique populations served by this Agreement. To the extent that TennCare Select medical management procedures are different from the CONTRACTOR's "TennCare Contractor Risk Agreement" medical management procedures, the CONTRACTOR shall obtain written approval from TENNCARE unless otherwise directed or approved by TENNCARE

2.24.1.5 The CONTRACTOR shall submit policies and procedures and other deliverables specified by TENNCARE to TENNCARE for review and/or written approval in the format and within the time frames specified by TENNCARE. The CONTRACTOR shall make any changes requested by TENNCARE to policies and procedures or other deliverables and in the time frames specified by TENNCARE.

2.24.1.6 As provided in this Agreement, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

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2.24.2 Behavioral Health Advisory Committee

The CONTRACTOR shall establish a behavioral health advisory committee that is accountable to the CONTRACTOR's governing body to provide input and advice regarding all aspects of the provision of behavioral health services according to the following requirements:

- 2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include families of adults with serious and/or persistent mental illness (SPMI) and families of children with serious emotional disturbance (SED);
- 2.24.2.2 There shall be geographic diversity;
- 2.24.2.3 There shall be cultural and racial diversity;
- 2.24.2.4 There shall be representation by providers and consumers (or family members of consumers) of substance abuse services;
- 2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee shall have input into policy development, planning for services, service evaluation, and member, family member and provider education;
- 2.24.2.6 Meetings shall be held at least quarterly;
- 2.24.2.7 Travel costs shall be paid by the CONTRACTOR;
- 2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.17; and
- 2.24.2.9 The CONTRACTOR, as membership changes, shall submit current membership lists to the State.

2.24.3 Performance Standards

The CONTRACTOR agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment XV.

2.24.4 Medical Records Requirements

- 2.24.4.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.
- 2.24.4.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:
 - 2.24.4.2.1 Confidentiality of medical records;
 - 2.24.4.2.2 Medical record documentation standards; and
 - 2.24.4.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:
 - 2.24.4.2.3.1 Medical records shall be maintained or available at the site where covered services are rendered;

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- 2.24.4.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section 2.24.4.2.3.3. below) be given copies thereof upon request;
- 2.24.4.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and
- 2.24.4.2.3.4 Performance goals to assess the quality of medical record keeping.
- 2.24.4.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.
- 2.24.4.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

2.24.5 Location of Non-Responsive TennCare Eligibles

The CONTRACTOR agrees to attempt to locate "non-responsive TennCare eligibles" that have been enrolled in the CONTRACTOR's plan. Non-responsive TennCare eligibles are persons identified by TennCare who have not responded to re-verification attempts and who have not (and whose family members have not) accessed services during the period of review. Within 90 days of identification, the CONTRACTOR shall attempt to reach each non-responsive TennCare eligible identified by TennCare to the CONTRACTOR and assigned to TennCare Select effective July 1, 2001. The CONTRACTOR shall attempt to reach each non-responsive TennCare eligible telephonically using the phone number provided by TennCare. Upon placement of the call, if the CONTRACTOR receives a message that the phone number has been changed, the CONTRACTOR shall update the enrollee's phone number in its system and make at least three documented attempts to contact said enrollee at the new number to obtain the enrollee's new address. If successful, the CONTRACTOR will forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. If TennCare does not provide a telephone number, the CONTRACTOR shall make and document at least one attempt to contact the non-responsive TennCare eligible through other publicly available information resources. In addition, the CONTRACTOR shall monitor claims activity for non-responsive TennCare eligibles. In the event the CONTRACTOR receives a claim for payment on behalf of a non-responsive TennCare eligible, the CONTRACTOR shall contact the provider and request the enrollee's phone number and address on file with the provider. The CONTRACTOR shall make at least three documented attempts to contact the enrollee at the location provided by the provider to confirm the enrollee's address. Once confirmed, the CONTRACTOR shall forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. The CONTRACTOR shall complete this process within 45 days for other non-responsive TennCare eligible as they are identified by TennCare to the CONTRACTOR.

2.25 MONITORING

2.25.1 General

- 2.25.1.1 TENNCARE, in its daily activities, shall monitor the CONTRACTOR for compliance with the provisions of this Agreement.
- 2.25.1.2 TENNCARE, CMS, or their representatives shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Monitoring activities shall include, but not be limited

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to, inspection of the CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. TENNCARE will emphasize case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes.

- 2.25.1.3 TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

2.25.2 Facility Inspection

TENNCARE, CMS, or their representatives may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the CONTRACTOR in fulfilling the obligations under this Agreement. Inspections may be made at anytime during the Agreement period and without prior notice.

2.25.3 Inspection of Work Performed

TENNCARE, CMS, or their representatives shall, at all reasonable times, have the right to enter into the CONTRACTOR's premises, or such other places where duties of this Agreement are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The CONTRACTOR and all other subcontractors or providers shall supply reasonable access to all facilities and assistance for TENNCARE's representatives. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

2.25.4 Approval Process

- 2.25.4.1 As specified by TENNCARE, TENNCARE must approve various deliverables/items before they can be implemented by the CONTRACTOR.
- 2.25.4.2 At any time that approval of TENNCARE is required in this Agreement, such approval shall not be considered granted unless TENNCARE issues its approval in writing.
- 2.25.4.3 TENNCARE shall specify the deliverables (see Attachment XIII) to be submitted to TENNCARE, whether they require prior approval or not, deliverable instructions, submission and approval time frames, and technical assistance as required.
- 2.25.4.4 Should TENNCARE not respond to a submission of a deliverable in the amount of time agreed to by TENNCARE, the CONTRACTOR shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or withholds shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the item if it is determined by TENNCARE to be in the best interest of the TennCare program.

2.25.5 Availability of Records

- 2.25.5.1 The CONTRACTOR shall ensure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Unit (TBI MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to TennCare enrollees.

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- 2.25.5.2 The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. The CONTRACTOR shall send all records to be sent by mail to TENNCARE within twenty (20) business days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.
- 2.25.5.3 The CONTRACTOR and any of its subcontractors, providers or any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.
- 2.25.5.4 The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:
- 2.25.5.4.1 Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or subcontractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury and any duly authorized governmental agency, including federal agencies; and
- 2.25.5.4.2 Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.
- 2.25.5.5 The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified person or organization to conduct the audits.

2.25.6 Audit Requirements

The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution

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

2.25.7 Independent Review of the CONTRACTOR

2.25.7.1 The CONTRACTOR shall cooperate fully with TENNCARE's External Quality Review Organization (EQRO) which will conduct a periodic and/or an annual independent review of the CONTRACTOR.

2.25.7.2 The CONTRACTOR shall cooperate fully with any evaluation of the TennCare program conducted by CMS.

2.25.8 Accessibility for Monitoring

For purposes of monitoring under this Agreement, the CONTRACTOR shall make available to TENNCARE or its representative and other authorized state and federal personnel, all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the MCO. The monitoring shall occur periodically during the Agreement period and may include announced or unannounced visits, or both.

2.25.9 Corrective Action Requirements

2.25.9.1 If TENNCARE determines that the CONTRACTOR is not in compliance with one or more requirements of this Agreement, TENNCARE will issue a notice of deficiency identifying the deficiency(ies), follow-up recommendations/requirements (e.g., a request for a corrective action plan), and time frames for follow-up.

2.25.9.2 Upon receipt of a notice of deficiency(ies) from TENNCARE, the CONTRACTOR shall comply with all recommendations/requirements made in writing by TENNCARE within the time frames specified by TENNCARE.

2.25.9.3 The CONTRACTOR shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the Agreement.

2.26 SUBCONTRACTS

2.26.1 Subcontract Relationships and Delegation

If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

2.26.1.1 The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

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- 2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- 2.26.1.3 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;
- 2.26.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and
- 2.26.1.5 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2.12 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

2.26.2 Legal Responsibility

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the MCO covered thereunder including all subcontracts/subcontractors. The CONTRACTOR shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontract for purposes of this Agreement without prior written approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out in compliance with the Agreement.

2.26.3 Prior Approval

All subcontracts, as defined in Section 1 of this Agreement, and revisions thereto shall be approved in advance in writing by TENNCARE. The CONTRACTOR shall revise subcontracts as directed by TENNCARE. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to TENNCARE within thirty (30) calendar days of execution. This written prior approval requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 1.

2.26.4 Subcontracts for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision or management of behavioral health services, the subcontract shall be specific to the TennCare program, and the CONTRACTOR shall comply with the requirements in Section 2.6.1.2 regarding integration of physical health and behavioral health services.

2.26.5 Standards

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Agreement. This includes, but is not limited to, Sections 2.19, 2.21.6, 2.25.5, 2.25.6, 2.25.8, 2.25.9, 5.1, 5.7, 5.20, and 5.21 of this Agreement.

2.26.6 Quality of Care

If the subcontract is for the purpose of securing the provision of covered services, the subcontract shall specify that the subcontractor adhere to the quality requirements the CONTRACTOR is held to.

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2.26.7 Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions

The CONTRACTOR shall provide instruction for all direct service subcontractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.26.8 Children in State Custody

The CONTRACTOR shall include in its subcontracts a provision stating that subcontractors are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral health services covered by TENNCARE.

2.26.9 Assignability

Transportation and claims processing subcontracts shall include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee; i) at the State's discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement shall include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.10 Claims Processing

2.26.10.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR shall be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.10.2 As required in Section 2.30.18 of this Agreement, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations.

2.26.11 HIPAA Requirements

The CONTRACTOR shall require all its subcontractors to adhere to HIPAA requirements.

2.26.12 Compensation for Utilization Management Activities

Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall ensure, consistent with 42 CFR 438.210(e) that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

2.26.13 Notice of Subcontractor Termination

2.26.13.1 When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCL.

2.26.13.2 TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

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2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

2.27.1 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity under the HIPAA regulations and agrees to comply with all applicable HIPAA regulations.

2.27.2 In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum:

2.27.2.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations;

2.27.2.2 Transmit/receive from/to its providers, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;

2.27.2.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR and its providers and/or subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Agreement in accordance with Section 5.2;

2.27.2.4 Ensure that Protected Health Information (PHI) data exchanged between the CONTRACTOR and TENNCARE is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations shall be de-identified to protect the individual enrollee's PHI under the privacy act;

2.27.2.5 Ensure that disclosures of PHI from the CONTRACTOR to TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: treatment, payment, or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to TENNCARE from the CONTRACTOR shall be as permitted and/or required under the law;

2.27.2.6 Report to TENNCARE within five (5) calendar days of becoming aware of any use or disclosure of PHI in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;

2.27.2.7 Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section 2.27;

2.27.2.8 Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;

2.27.2.9 Make an enrollee's PHI data accessible to TENNCARE immediately upon request by TENNCARE;

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- 2.27.2.10 Make available to TENNCARE within ten (10) calendar days of notice by TENNCARE to the CONTRACTOR such information as in the CONTRACTOR's possession and is required for TENNCARE to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, the CONTRACTOR shall provide TENNCARE with the following information:
- 2.27.2.10.1 The date of disclosure;
- 2.27.2.10.2 The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person;
- 2.27.2.10.3 A brief description of the PHI disclosed, and
- 2.27.2.10.4 A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.
- 2.27.2.11 In the event that the request for an accounting of disclosures is submitted directly to the CONTRACTOR, the CONTRACTOR shall within two (2) business days forward such request to TENNCARE. It shall be TENNCARE's responsibility to prepare and deliver any such accounting requested. Additionally, the CONTRACTOR shall institute an appropriate record keeping process and procedures and policies to enable the CONTRACTOR to comply with the requirements of this Section;
- 2.27.2.12 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.
- 2.27.2.13 Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:
- 2.27.2.13.1 Use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI the CONTRACTOR creates, receives, maintains, or transmits on behalf of TENNCARE.
- 2.27.2.13.2 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.
- 2.27.2.13.3 Agree to report to TENNCARE's privacy officer as soon as possible but within two (2) business days any unauthorized use or disclosure of enrollee PHI not otherwise permitted or required by HIPAA. Such immediate report shall include any security incident of which the CONTRACTOR becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained by the CONTRACTOR. The CONTRACTOR shall also notify TENNCARE's privacy officer within two (2) business days of any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the CONTRACTOR's system.
- 2.27.2.14 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections

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- 2.21.6 and 2.25.6 of this Agreement the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which can not feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;
- 2.27.2.15 Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164;
 - 2.27.2.16 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
 - 2.27.2.17 Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint;
 - 2.27.2.18 Provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
 - 2.27.2.19 Track training of CONTRACTOR staff and maintain signed acknowledgements by staff of the CONTRACTOR's HIPAA policies;
 - 2.27.2.20 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations;
 - 2.27.2.21 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;
 - 2.27.2.22 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization;
 - 2.27.2.23 Continue to protect personally identifiable information relating to individuals who are deceased;
 - 2.27.2.24 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;
 - 2.27.2.25 Make available PHI in accordance with 45 CFR 164.524;
 - 2.27.2.26 Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526; and
 - 2.27.2.27 Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.
- 2.27.3 The CONTRACTOR shall track all security incidents as defined by HIPAA, and, as required by Section 2.30.19, the CONTRACTOR shall periodically report in summary fashion such security incidents (see Section 2.30.19). The CONTRACTOR shall notify TENNCARE's privacy officer within two (2) business days of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.

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- 2.27.4 TENNCARE and the CONTRACTOR are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of CONTRACTOR's information system, as defined by TCA 47-18-2107, the CONTRACTOR shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include but not be limited to mailing notifications to affected members. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with TENNCARE's express written approval.
- 2.27.5 In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:
- 2.27.5.1 Make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations;
 - 2.27.5.2 Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight;
 - 2.27.5.3 Adopt a mechanism for resolving any issues of non-compliance as required by law; and
 - 2.27.5.4 Establish similar HIPAA data partner agreements with its subcontractors and other business associates.

2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

- 2.28.1 The CONTRACTOR shall comply with Section 5.21 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.
- 2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding the CONTRACTOR's non-discrimination policies and procedures and all applicable non-discrimination compliance requirements of the TennCare program. The CONTRACTOR shall be able to show documented proof of such instruction.
- 2.28.3 The CONTRACTOR shall develop written policies and procedures for non-discrimination in the provision of services to persons with Limited English Proficiency as well as those that need assistance with communication in alternative formats. These policies and procedures shall be prior approved in writing by TENNCARE.
- 2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.
- 2.28.5 The CONTRACTOR shall ask all staff to provide their race or ethnic origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.
- 2.28.6 The CONTRACTOR shall ask all providers for their race or ethnic origin. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.
- 2.28.7 The CONTRACTOR shall develop written policies and procedures for the investigation of complaints of discrimination. These policies and procedures shall be prior approved in writing by TENNCARE.

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- 2.28.8 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the TennCare program), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare MCO. The CONTRACTOR shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; CONTRACTOR's resolution, if resolved; and name of CONTRACTOR staff person responsible for adjudication of the complaint.
- 2.28.9 The CONTRACTOR shall develop and have available a standardized complaint form to provide to a complainant upon request. This complaint form shall be in a format specified by TENNCARE.
- 2.28.10 The CONTRACTOR shall report on non-discrimination activities as described in Section 2.30.20.

2.29 PERSONNEL REQUIREMENTS

2.29.1 Staffing Requirements

- 2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Agreement.
- 2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. In the event of a change to any of the key staff identified in Section 2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change.
- 2.29.1.3 The minimum key staff requirements are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person;
- 2.29.1.3.1 A full-time administrator/project director dedicated to the TennCare program who has clear authority over the general administration and day-to-day business activities of this Agreement;
- 2.29.1.3.2 A full-time staff person dedicated to the TennCare program who will assist the CONTRACTOR in the transition from the CONTRACTOR's implementation team to regular ongoing operations. This person shall be onsite in Tennessee from the start date of this Agreement through at least one-hundred and twenty (120) days after the start date of operations.
- 2.29.1.3.3 A full-time Medical Director dedicated to the TennCare program who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;
- 2.29.1.3.4 A full-time senior executive dedicated to the TennCare program who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. This person shall oversee and be responsible for all behavioral health activities;
- 2.29.1.3.5 A full-time chief financial officer dedicated to the TennCare program responsible for accounting and finance operations, including all audit activities;

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- 2.29.1.3.6 A full-time staff information systems director/manager dedicated to the TennCare program responsible for all CONTRACTOR information systems supporting this Agreement who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting this Agreement including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;
- 2.29.1.3.7 A staff person designated as the contact available after hours for the "on-call" TennCare Solutions staff to contact with service issues;
- 2.29.1.3.8 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;
- 2.29.1.3.9 A full-time staff person dedicated to the TennCare program responsible for member services, who shall communicate with TENNCARE regarding member service activities;
- 2.29.1.3.10 A full-time staff person dedicated to the TennCare program responsible for provider services and provider relations, including all network management issues. This person shall be responsible for communicating with TENNCARE regarding provider service and provider relations activities;
- 2.29.1.3.11 A staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement;
- 2.29.1.3.12 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;
- 2.29.1.3.13 A staff person responsible for all quality management activities. This person shall be a physician or registered nurse licensed in the State of Tennessee;
- 2.29.1.3.14 A staff person responsible for all appeal system resolution issues;
- 2.29.1.3.15 A staff person responsible for all claims management activities;
- 2.29.1.3.16 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;
- 2.29.1.3.17 A staff person responsible for all MCO case management and care coordination issues, including but not limited to, disease management activities and coordination between physical and behavioral health services;
- 2.29.1.3.18 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members' interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;
- 2.29.1.3.19 A staff person responsible for TENNderCare services;

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- 2.29.1.3.20 A staff person responsible for working with the Department of Children's Services;
- 2.29.1.3.21 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;
- 2.29.1.3.22 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the Care Coordination Committee and the Claims Coordination Committee as described in Section 2.9.8;
- 2.29.1.3.23 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination; and
- 2.29.1.3.24 A staff person designated for interfacing and coordinating with the TDMHDD Planning and Policy Council.
- 2.29.1.3.25 A specific staff person or persons designated as a liaison for the Department of Children's Services (DCS) which shall be identified, in writing, to TENNCARE and the DCS. The DCS liaison person(s) will be responsible for responsibilities described in Section 3.1.1 of this Agreement.
- 2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, MCO case management and care coordination, quality management, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.
- 2.29.1.5 The CONTRACTOR shall have a sufficient number of care coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.
- 2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section 2.21.9.
- 2.29.1.7 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section 2.29.1.3. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.
- 2.29.1.8 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, financial staff, member services staff, provider services staff, provider relations staff, UM staff, appeals staff, MCO case management staff, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.
- 2.29.1.9 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

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2.29.2 Licensure

The CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law.

2.29.3 Board of Directors

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

2.29.4 Employment and Contracting Restrictions

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:

- 2.29.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;
- 2.29.4.2 Have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- 2.29.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section 2.29.4.2 of this Agreement; and
- 2.29.4.4 Have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

2.30 REPORTING REQUIREMENTS

2.30.1 General Requirements

- 2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports.
- 2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.

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2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Agreement, according to the schedule below:

DELIVERABLES	DUE DATE
Daily Reports	Within two (2) business days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	20th of the following month.
Quarterly Reports	30th of the following month.
Semi-Annual Reports	January 31 and July 31.
Annual Reports	Ninety (90) calendar days after the end of the calendar year
On Request Reports	Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.
Ad Hoc Reports	Within ten (10) business days from the date of the request unless otherwise specified by TENNCARE.

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE. Except as otherwise specified by TENNCARE, all reports shall be specific to the Grand Region covered by this Agreement.

2.30.1.5 Except as otherwise provided in this Agreement, the CONTRACTOR shall submit all reports to the Bureau of TennCare.

2.30.1.6 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.2 Eligibility, Enrollment and Disenrollment Reports

2.30.2.1 The CONTRACTOR shall comply with the requirements in Section 2.23.5 regarding eligibility and enrollment data exchange.

2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Administrative Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with administrative payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received an administrative payment.

2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Administrative Payment Report* in the event it has members for whom an administrative payment has not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise. The CONTRACTOR shall report this information in the formats provided in Attachment XIII, Exhibit A.

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- 2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.
- 2.30.2.5 Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR shall reconcile enrollee eligibility data and administrative fee payments received from TennCare with an ad hoc report mutually agreed to by TennCare and the CONTRACTOR to facilitate timely identification of children in state custody or children transitioning out of state custody.
- 2.30.2.6 Pursuant to Section 2.4.6.2, the CONTRACTOR shall provide a listing of any enrollees for whom it has conflicting information to TennCare within ten (10) calendar days of the last day of each month.
- 2.30.2.7 The CONTRACTOR shall submit an *Immediate Eligibility Invoice* monthly in accordance with Attachment XIII, Exhibit N.
- 2.30.3 **LEFT BLANK INTENTIONALLY**
- 2.30.4 **Specialized Service Reports**
 - 2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18).
 - 2.30.4.2 The CONTRACTOR shall submit a quarterly *Mental Health Case Management Report* that provides information on mental health case management appointments and refusals (see Section 2.6.5). The minimum data elements required are identified in Attachment XIII, Exhibit O.
 - 2.30.4.3 The CONTRACTOR shall submit an annual *Supported Employment Report* that reports on the percent of SPMI adults receiving supported employment services that are gainfully employed in either part-time or full-time capacity for a continuous ninety (90) day period (defined as the number of adults receiving supported employment for a continuous ninety (90) day period divided by the number of SPMI adults receiving supported employment services during the year) and an analysis of the findings with any action or follow-up planned as a result of the findings.
 - 2.30.4.4 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.6.5.8) including the data elements listed in Attachment XIII, Exhibit P. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all data elements shall be reported for each individual crisis service provider.
 - 2.30.4.5 The CONTRACTOR shall submit a weekly *Member CRG/TPG Assessment Report* that contains information regarding the CRG assessments and TPG assessments (see Section 2.6.5.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. For purposes of this weekly *Member CRG/TPG Assessment Report*, the weekly report shall be due no later than 12:00 Noon, each Tuesday. The minimum data elements required are identified in Attachment XIII, Exhibit Q of this Agreement.

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- 2.30.4.6 On a quarterly basis the CONTRACTOR shall submit a *Rejected CRG/TPG Assessments Report* that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments.
- 2.30.4.7 The CONTRACTOR shall submit an annual *CRG/TPG Assessments Audit Report*. The report shall contain the results of the CONTRACTOR's audits for the prior year of CRG/TPG assessments for accuracy and conformity to state policies and procedures.
- 2.30.4.8 The CONTRACTOR shall annually submit to TENNCARE its methodology for conducting the CRG/TPG assessment audits on March 1.
- 2.30.4.9 The CONTRACTOR shall submit a quarterly *Adverse Occurrences Report* that summarizes all adverse occurrences and their resolutions as reported to the CONTRACTOR by its providers.
- 2.30.4.10 The CONTRACTOR shall submit a quarterly *TENNderCare Report*.

2.30.5 Disease Management Reports

- 2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter.
- 2.30.5.2 The CONTRACTOR shall submit on July 1 an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the eligibility criteria and the method used to identify and enroll eligible members, the passive participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, a description of stratification levels for each DM program including member criteria and associated interventions, a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation, a summary of member satisfaction with the DM program, a written analysis of the data presented, a description of proposed changes to program, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7.
- 2.30.5.3 The CONTRACTOR shall submit annually an updated *Disease Management Program Description* to include at a minimum the disease management components listed in Sections 2.8.1.4 through 2.8.1.5 of this Agreement.

2.30.6 Service Coordination Reports

- 2.30.6.1 MCO Case Management Reports
 - 2.30.6.1.1 The CONTRACTOR shall submit annually an updated *MCO Case Management Program Description* to TENNCARE describing the CONTRACTOR's MCO case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for MCO case management, the process the CONTRACTOR uses to inform members and providers of the availability of MCO case management, a description of the MCO case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its MCO case management program.
 - 2.30.6.1.2 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.4 of this Agreement by July 1 of each year.

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- 2.30.6.1.3 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report*. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management.
- 2.30.6.2 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.7).
- 2.30.6.3 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.
- 2.30.6.4 The CONTRACTOR shall submit a *Pharmacy Services Report - On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.7 Provider Network Reports

- 2.30.7.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical and behavioral health providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, and emergency and non-emergency transportation providers. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. The report shall be sorted by provider type. The CONTRACTOR shall submit this report by the 5th of each month, and upon TENNCARE request. Each monthly *Provider Enrollment File* shall include information on all providers of TennCare health services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
- 2.30.7.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards. (See Section 2.11.1.10.)
- 2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. This report shall be submitted using the format described by TennCare. (See Section 2.11.2.)
- 2.30.7.4 The CONTRACTOR shall submit an annual *Report of Essential Hospital Services* by September 1 of each year. The CONTRACTOR shall use the format in Attachment XIII, Exhibit G.
- 2.30.7.5 The CONTRACTOR shall submit a quarterly *Behavioral Health Initial Appointment Timeliness Report* that shall include the average time between the intake assessment appointment and the member's next scheduled appointment or admission. The report shall provide this information by type of service and shall include an analysis of the findings and any actions or follow-up planned as a result of the findings.

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2.30.7.6 The CONTRACTOR shall submit an annual *FQHC Report* by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment XIII, Exhibit.

2.30.7.7 The CONTRACTOR shall submit a monthly *Institutions for Mental Diseases (IMD) Out-of-State Report* on the use of IMDs utilized outside of the State of Tennessee. The report shall be submitted by the 5th of each month for the previous month.

2.30.8 **Provider Agreement Report**

The CONTRACTOR shall submit a monthly *Single Case Agreements Report* using the format as described by TennCare. (See Section 2.12.4.)

2.30.9 **Provider Payment Reports**

2.30.9.1 The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.15.)

2.30.9.2 The CONTRACTOR shall submit a weekly *Invoice* to notify the State of the amount to be paid to providers at least 72 hours in advance of distribution of provider checks.

2.30.9.3 The CONTRACTOR shall submit a *Check Register Report* with the weekly *Invoice* to support the payments released to providers.

2.30.9.4 The CONTRACTOR shall submit a *Claims Data Extract* within seven (7) calendar days after the CONTRACTOR's request of the funds which shall be generated from the managed care claims processing system supporting the release of provider payments. (See Section 2.13.8)

2.30.9.5 The CONTRACTOR shall submit a *Reconciliation Report* seven (7) days of the claims data extract for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle.

2.30.9.6 If the CONTRACTOR does not automatically credit TennCare for receivables within ninety (90) calendar days, the CONTRACTOR shall submit a *Provider Payment Issue Report* and shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts		Forwarded to Collections
	45-Day	90-Day	
< \$10	None Required		
\$10 - \$49.99	✓		
\$50 - \$99.99	✓	✓	
\$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

2.30.9.6.1 The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.

2.30.9.6.2 Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

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- 2.30.9.7 If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Aged Accounts Receivable Report*. The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.
- 2.30.9.8 If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Uncollectible Accounts Report*, in a format described by TENNCARE, for accounts meeting the following criteria:
- 2.30.9.8.1 the account proves to be uncollectible after 120 calendar days, or
- 2.30.9.8.2 the provider account owner has gone out-of-business, or
- 2.30.9.8.3 the provider account owner has declared bankruptcy.
- 2.30.9.9 In addition to the *Uncollectible Accounts Report*, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.
- 2.30.9.10 The Contractor shall submit a monthly *Outstanding Checks Report* detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due within fifteen (15) business days after the end of the month.

2.30.10 Utilization Management Reports

- 2.30.10.1 The CONTRACTOR shall annually submit, by July 30th of each year, a UM program description and an associated work plan and evaluation. These documents must be prior approved by the CONTRACTOR's oversight committee prior to submission to TENNCARE. The annual evaluation shall include an analysis of findings and actions taken.
- 2.30.10.2 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.
- 2.30.10.3 The CONTRACTOR shall provide quarterly *Cost and Utilization Summaries*. These summaries shall report on services paid during the previous quarter. The summaries shall include all data elements as required by TennCare. The CONTRACTOR shall provide the reports separately for the following populations: Groups 1A and 1B, Group 2, and Groups 3 through 6.
- 2.30.10.4 The CONTRACTOR shall identify and report the number of members who incurred claims in excess of twenty-five thousand dollars (\$25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.
- 2.30.10.5 The CONTRACTOR shall submit quarterly *Prior Authorization Reports* that include information by service and separately for adults and children, on the number of requests received, number processed, number approved, number denied, and denial reason.

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- 2.30.10.6 The CONTRACTOR shall submit a copy of the *Referral Provider Listing* (see Section 2.14.3.5), a data file of the provider information used to create the listing, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the referral provider listings mailed to providers, the date mailed, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section 2.14.3.5.
- 2.30.10.8 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* to TENNCARE no later than February 28th and August 31st each year identifying interventions initiated for members who exceeded the defined threshold for ED usage.

2.30.11 Quality Management/Quality Improvement Reports

- 2.30.11.1 The CONTRACTOR shall annually submit, by July 30, an approved (by the CONTRACTOR's QM/QI Committee) QM/QI Program Description, Associated Work Plan, and Annual Evaluation.
- 2.30.11.2 The CONTRACTOR shall submit an annual *Report on Performance Improvement Projects* that includes the information specified in Section 2.15.3. The report shall be submitted annually on July 30.
- 2.30.11.3 The CONTRACTOR shall submit an annual *Report of Performance Indicator Results, Audited CAHPS Results and Audited HEDIS Results* by June 15 of each year (see Sections 2.15.4, 2.15.6 and 2.15.7).
- 2.30.11.4 The CONTRACTOR shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.
- 2.30.11.5 The CONTRACTOR shall submit its annual reevaluation of accreditation status based on HEDIS scores immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.

2.30.12 Customer Service Reports/Provider Service Reports

- 2.30.12.1 Member Services/UM/ED Phone Line Reports
 - 2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services and UM Phone Line Report*. The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report as described by TennCare.
 - 2.30.12.1.2 The CONTRACTOR shall submit a quarterly *24/7 Nurse Triage Line Report* that lists the total calls received by the 24/7 nurse triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2.18.4.7 of this Agreement, such calls shall be separately delineated in the report in accordance with the requirements described in Section 2.30.12.1.3 of this Agreement.
 - 2.30.12.1.3 The CONTRACTOR shall submit a quarterly *ED Assistance Tracking Report* that provides the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report shall include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the nurse triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2.30.12.1.2.

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- 2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.
 - 2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.
 - 2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement (see Section 2.18.7.3).
 - 2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone. The data shall be reported by month.
- 2.30.13 Fraud and Abuse Reports**
- 2.30.13.1 The CONTRACTOR shall submit an annual *Fraud and Abuse Activities Report*. This report shall summarize the results of its fraud and abuse compliance plan (see Section 2.20) and other fraud and abuse prevention, detection, reporting, and investigation measures, and should cover results for the fiscal year ending June 30. The report shall be submitted by September 30 of each year in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).
 - 2.30.13.2 The CONTRACTOR shall submit an annual fraud and abuse compliance plan (see Section 2.20.3 of this Agreement).
 - 2.30.13.3 On an annual basis the CONTRACTOR shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.
- 2.30.14 Financial Management Reports**
- 2.30.14.1 Third Party Liability (TPL) Resources Reports
 - 2.30.14.1.1 The CONTRACTOR shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE.
 - 2.30.14.1.2 The CONTRACTOR shall submit an *Other Insurance Report* that provides information on any members who have other insurance. This report shall be submitted in a format and frequency described by TENNCARE.

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2.30.14.2 Financial Reports to TENNCARE

- 2.30.14.2.1 For the purpose of monitoring actual medical expenses, TennCare shall establish a Medical Fund Target by eligibility grouping for TennCare Select. The CONTRACTOR shall submit a monthly *Medical Fund Target Report* with cumulative year to date calculation using the format described by TennCare. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.16.3 and 2.23.4.
- 2.30.14.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.8 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.
- 2.30.14.2.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year (see Section 2.21.9).

2.30.14.3 TDCI Financial Reports

- 2.30.14.3.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report*. This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Agreement. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.
- 2.30.14.3.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report*. If necessary, the CONTRACTOR shall revise the calendar year budget based on its actual results of operations. Any revisions to the budget shall include narratives explaining the assumptions and calculations utilized in making the revisions.
- 2.30.14.3.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-108. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report shall also be accompanied by the Medical Loss Ratio report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Loss Ratio report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).
- 2.30.14.3.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report*. These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 1 (covering third quarter of current year). Each quarterly report shall also contain

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an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on September 1) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

2.30.14.3.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements*. Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:

2.30.14.3.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.

2.30.14.3.5.2 Any requests for extension of the May 1 submission date must be granted by the Office of the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

2.30.14.3.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

2.30.15 Claims Management Reports

2.30.15.1 The CONTRACTOR shall submit a monthly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section 2.22.6) and shall report on the number and percent of claims that are paid accurately. As provided in Section 2.22.6.6, if the CONTRACTOR subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor shall include the results of the internal audit conducted in compliance with Section 2.22.6 and shall report on the number and percent of claims that are paid accurately.

2.30.15.2 The CONTRACTOR shall submit a quarterly *Explanation of Benefits (EOB) Report*. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section 2.22.8.)

2.30.15.3 The CONTRACTOR shall submit a weekly *Claims Activity Report*. This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, and total amount paid by the categories of service specified by TENNCARE.

2.30.16 Information Systems Reports

2.30.16.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section 2.23.1.6.

2.30.16.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section 2.23.4) and transmitted electronically to TENNCARE on a weekly basis.

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- 2.30.16.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section 2.30.14.2.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the Medical Fund Target report.
- 2.30.16.4 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.
- 2.30.16.5 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the CONTRACTOR's span of control.
- 2.30.16.6 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TENNCARE. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and written approval by TENNCARE.

2.30.17 Administrative Requirements Reports

The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee* regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

2.30.18 Subcontract Reports

- 2.30.18.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.
- 2.30.18.2 In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

2.30.18.2.1 *General Controls*

2.30.18.2.1.1 Personnel Policies

2.30.18.2.1.2 Segregation of Duties

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- 2.30.18.2.1.3 Physical Access Controls
- 2.30.18.2.1.4 Hardware and System Software
- 2.30.18.2.1.5 Applications System Development and Modifications
- 2.30.18.2.1.6 Computer Operations
- 2.30.18.2.1.7 Data Access Controls
- 2.30.18.2.1.8 Contingency and Business Recovery Planning
- 2.30.18.2.2 *Application Controls*
 - 2.30.18.2.2.1 Input
 - 2.30.18.2.2.2 Processing
 - 2.30.18.2.2.3 Output
 - 2.30.18.2.2.4 Documentation Controls

2.30.19 HIPAA Reports

The CONTRACTOR shall submit a Privacy/Security Incident Report. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

2.30.20 Non-Discrimination Compliance Reports

- 2.30.20.1 The CONTRACTOR shall submit an annual *Summary Listing of Servicing Providers* that includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race or ethnic origin and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The CONTRACTOR shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by TENNCARE.
- 2.30.20.2 The CONTRACTOR shall submit a quarterly *Supervisory Personnel Report* that contains a summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE.
- 2.30.20.3 The CONTRACTOR shall submit a quarterly *Alleged Discrimination Report*. The report shall include a listing of all complaints alleging discrimination filed by employees, members, providers and subcontractors in which discrimination is alleged by the CONTRACTOR's MCO. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint.

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- 2.30.20.4 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in provision of services to members with Limited English Proficiency. This shall include a report that lists all interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, and hours services are available.
- 2.30.20.5 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan and Assurance of Non-Discrimination* to TENNCARE. The signature date of the CONTRACTOR's Title VI Compliance Plan shall coordinate with the signature date of the CONTRACTOR's Assurance of Non-Discrimination.

2.30.21 Terms and Conditions Reports

- 2.30.21.1 Quarterly, by January 30, April 30, July 30, and October 30 each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section 5.7.
- 2.30.21.2 Pursuant to Section 5.30, on a semi-annual basis the CONTRACTOR shall submit the attestation in Attachment II.
- 2.30.21.3 The CONTRACTOR shall maintain documentation that demonstrates the cost effectiveness of any non-covered services that are provided to TennCare enrollees and for which the CONTRACTOR seeks reimbursement from the state. A report summarizing all such documentation for the preceding year shall be submitted by the CONTRACTOR no later than sixty (60) calendar days after the end of each state fiscal year.

11. Section 5 shall be deleted and replaced with a new Section 4 subsequent sections shall be renumbered, including any references thereto. The new Section 4 shall read as follows:

4 PAYMENT TERMS AND CONDITIONS

4.1 Administrative Fee

- 4.1.1 The CONTRACTOR shall be paid a fixed fee per member per month for the administration of TennCare Select according to the requirements of this Agreement. The administrative fee to be paid shall be described in Attachment XVI of this Agreement.
- 4.1.2 TennCare or its appointed agent shall make payment by the fifth working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees certified by TENNCARE multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the CONTRACTOR for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.
- 4.1.3 Payment for enrollees shall start the effective date of the enrollee's enrollment in the plan.
- 4.1.4 The CONTRACTOR agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the CONTRACTOR for enrollees retroactively terminated from TennCare Select.
- 4.1.5 Administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XVI will not include payment for children in state custody for whom Immediate Eligibility was established and who were not subsequently found to be TennCare eligible. TennCare shall make a separate payment for said children upon receipt of an invoice from the CONTRACTOR. The

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invoice shall be submitted to TENNCARE in the form and format specified in Attachment XIII, Exhibit N on a monthly basis. The administrative fee due shall be equal to the number of enrollees for whom Immediate Eligibility was established multiplied by a flat rate equal to the per member per month for Group 1.A, for the full 45 day eligibility period.

4.2 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

4.2.1 General

4.2.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 4.2.

4.2.1.2 The TennCare Select HEDIS score for the previous calendar year for each of the measures specified in Sections 4.2.2 and 4.2.3 will serve as the baseline rate in the NCQA minimum effect size change calculations (see Section 4.2.4 below).

4.2.2 Physical Health HEDIS Measures

4.2.2.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.2.2 below for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.4 below).

4.2.2.2 Incentive payments will be available for the following audited HEDIS measures:

4.2.2.2.1 Appropriate Treatment for Children with Upper Respiratory Infection (URI);

4.2.2.2.2 Childhood Immunization Status - MMR;

4.2.2.2.3 Children and Adolescents' Access to PCP – 7-11 year old age group;

4.2.2.2.4 Children and Adolescents' Access to PCP – 12-19 year old age group;

4.2.2.2.5 Well Child Visits – 3rd, 4th, 5th and 6th years of life; and

4.2.2.2.6 Adolescent Well Care Visits.

4.2.3 Behavioral Health HEDIS Measures

4.2.3.1 On July 1 of 2011, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures for which the CONTRACTOR scores at or above the 75th national Medicaid percentile, as calculated by NCQA.

4.2.3.1.1 Follow-up After Hospitalization for Mental Illness; and

4.2.3.1.2 Follow-up Care for Children Prescribed ADHD Medication.

4.2.3.2 Beginning on July 1, 2012, on July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.3 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.4 below).

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4.2.3.2.1 Follow-up After Hospitalization for Mental Illness; and

4.2.3.2.2 Follow-up Care for Children Prescribed ADHD Medication.

4.2.4 **NCQA Minimum Effect Size Change Methodology**

The NCQA minimum effect size change methodology is as follows:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

4.3 **Shared Risk Terms and Conditions**

4.3.1 **Populations**

Effective March 1, 2009, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The shared risk terms shall apply to the following populations as described in Section 2.4 of this Agreement: Group 1.A, Group 1.B, and Group 2.

4.3.2 **Components**

The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits. Additionally, there will be both an upside potential (bonus) as well as downside potential (risk). Bonus and the risk will be based on the following components as described below:

4.3.2.1 EPSDT, and

4.3.2.2 Medical Services Budget Target.

4.3.3 **Acuity Adjustment**

4.3.3.1 The parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology recommended by the State or its actuarial contractor.

4.3.3.2 The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population described above. As an integral part of evaluating the CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population described above. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population described above and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

4.3.4 **Mandates / Initiatives**

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Agreement as they are performed and interpreted as of March 1, 2009. As such, services provided as a result of compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Agreement as of March 1, 2009 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

4.3.5 **Risk Component**

4.3.5.1 The Shared Risk Model will require that a percent of the administrative fees be placed at risk. The Model will set ten percent (10%) of the administrative fee at risk.

4.3.5.2 The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
EPSDT Compliance	5.0%
Medical Services Budget Target	5.0%

4.3.5.2.1 *Increase EPSDT Compliance*

4.3.5.2.1.1 The target is based on the CONTRACTOR's reported screening rate according to the information contained in the CMS 416 Report for FFY 2007 which is 85%.

4.3.5.2.1.2 The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Agreement.

4.3.5.2.1.3 TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	Administrative Fee Adjustment
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annually with a 90 day lag
At Risk Portion: 5.0% of Administrative Fee (Budget)
Implementation Date: March 1, 2009

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4.3.5.2.2 *Medical Services Budget Target Initiative*

4.3.5.2.2.1 At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The estimated IBNR shall be reviewed and adjusted by the State's actuarial contractor prior to final determination of performance. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag

At Risk Portion: 5% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

4.3.6 **Performance Bonuses**

4.3.6.1 TennCare will establish a bonus pool for each Risk Initiative described below. The bonus pool will represent a total of ten percent (10%) of the administrative fee for the selected population (Group 1.A, Group 1.B, and Group 2) for the CONTRACTOR as described in Section 2.4 of this Agreement. The following Initiatives will be included in the Bonus Pool: EPSDT Compliance and Medical Service Budget Target (MSBT).

4.3.6.2 The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus (% of Admin Rate for Selected Population)
EPSDT Compliance	5.0%
Medical Service Budget Target	5.0%

4.3.6.3 The following tables identify the Performance Percentage Targets:

Additional Bonus Points

Performance – Percent Exceeding Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%
> 105% and ≤ 110%	60%
> 110% and ≤ 117%	100%

Performance – Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

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4.3.7 Risk and Bonus Payout Reconciliation

- 4.3.7.1 The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Payouts for the annual evaluation period shall be made by October 31 of the following year.
- 4.3.7.2 In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.
- 4.3.7.3 If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

4.4 HMO Payment

Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-124 thirty days after the end of each calendar year quarter. In the event the amount due pursuant to TCA 56-32-124 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

4.5 Payments to CONTRACTOR

The administrative fee payments and the premium tax payments specified in Section 4 and Attachment XVI of this Agreement as amended, shall represent payment in full. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at Tennessee Code Annotated § 56-32-201 et seq. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at Tennessee Code Annotated § 56-51-101 et seq. or any subsequent amendments thereto.

4.6 Maximum Liability

- 4.6.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed Three Hundred Eighty Three Million, One Hundred Thirty Thousand Dollars (\$383,130,000.00).
- 4.6.2 If the Agreement maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment described herein, the State shall adjust the Agreement maximum liability to accommodate the aforementioned circumstances. This adjustment shall be based on consultation with the State's independent actuary.
- 4.6.3 This Agreement does not obligate the State to pay a fixed minimum amount and does not create in the CONTRACTOR any rights, interests or claims of entitlement in any funds.

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4.6.4 The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Agreement or any extensions of the Agreement. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of these funds to the CONTRACTOR under this Agreement.

12. The renumbered Section 5.8.2.2 shall be amended by adding new Items B.25, B.26, B.27:

B.25	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.6.3.2 of this Agreement		\$1,000 per occurrence per case
B.26	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.6.5.9 of this Agreement		\$500 per month per Enrollee
B.27	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.6.5.9 of this Agreement		\$500 per occurrence per case

13. The existing Section 6-28 "Performance Guarantees" shall be deleted in its entirety and the newly renumbered Section 5 shall be amended by adding new Sections 5-28 through 5-33 and renumbering the existing Sections accordingly. The renumbered Section 5-33 shall be amended by deleting and replacing June 30, 2009 with June 30, 2010. The new and renumbered Sections shall read as follows:

5.28 Notice of Legal Action

The CONTRACTOR shall provide to TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, notice in writing by Certified Mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the CONTRACTOR, or an affiliate of the CONTRACTOR (including but not limited to a parent company), that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The Contractor shall also provide similar notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. It is the intent of this provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR'S financial viability and/or program operations or integrity.

5.29 CONTRACTOR Appeal Rights

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 et seq. for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action shall be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Agreement pending the final resolution of the contested action.

5.30 Prohibition of Illegal Immigrants

The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Agreement, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Agreement.

- 5.30.1 The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Agreement. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment II, hereto, semi-annually during the period of this Agreement. Such attestations shall be maintained by the contractor and made available to state officials upon request.
- 5.30.2 Prior to the use of any subcontractor in the performance of this Agreement, and semi-annually thereafter, during the period of this Agreement, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Agreement. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.
- 5.30.3 The Contractor shall maintain records for all personnel used in the performance of this Agreement. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- 5.30.4 The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.
- 5.30.5 For purposes of this Agreement, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Agreement.

5.31 Voluntary Buyout Program

- 5.31.1 The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.
- 5.31.2 The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.
- 5.31.3 The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.

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- 5.31.4 With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the VBP Contracting Restriction Waiver Request format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Agreement, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

5.32 Federal Economic Stimulus Funding

This Agreement requires the CONTRACTOR to provide products and/or services that are funded in whole or in part under the American Recovery and Reinvestment Act of 2009, Public Law 111-5, (Recovery Act). The CONTRACTOR is responsible for ensuring that all applicable requirements of the Recovery Act are met and that the CONTRACTOR provides information to the State as required by, but not limited to, the following:

- 5.32.1 The Recovery Act, including but not limited to the following sections of that Act:
- 5.32.1.1 Section 1606 – Wage Rate Requirements.
 - 5.32.1.2 Section 1512 – Reporting and Registration Requirements.
 - 5.32.1.3 Sections 902, 1514, and 1515 – General Accounting Office/Inspector General Access.
 - 5.32.1.4 Section 1553 – Whistleblower Protections.
 - 5.32.1.5 Section 1605 – Buy American Requirements for Construction Material.
- 5.32.2 Executive Office of the President, Office of Management and Budget (OMB) Guidelines as posted at http://www.whitehouse.gov/omb/recovery_default/, as well as OMB Circulars, including but not limited to A-102 and A-133 as posted at http://www.whitehouse.gov/omb/financial_offm_circulars/.
- 5.32.3 Federal Grant Award Documents.
- 5.32.4 Office of Tennessee Recovery Act Management Directives.

5.33 Contract Term of The Agreement

- 5.33.1 This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2010. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.
- 5.33.2 Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

14. Attachment I shall be deleted and replaced in its entirety so that the new Attachment I shall read as follows:

**ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS**

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

SERVICE	Mental Health Case Management
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DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week

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Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

- 1) All mental health case managers shall have, at a minimum, a bachelor’s degree;
- 2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
- 3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
- 4) Eighty percent (80%) of all mental health case management services should take place outside the case manager’s office;
- 5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children’s services, including mental health case management, shall be incorporated into the child’s treatment plan; and
- 6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

- 1) Services targeted to a specific group of individuals with severe mental illness;
- 2) Treatment, support and rehabilitation services provided directly by the ACT team;
- 3) Sharing of responsibility between team members and individuals served by the team;
- 4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
- 5) Comprehensive and flexible range of treatment and services;
- 6) Interventions occurring in community settings rather than in hospitals or clinic settings;
- 7) No arbitrary time limit on receiving services;
- 8) Individualized treatment, support and rehabilitation services;
- 9) Twenty-four (24) hour a day availability of services; and
- 10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services

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to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the "imminent" risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation
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DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members and are Certified Peer Support Specialists. These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and

original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

15. Attachment IV shall be amended by adding “Psychiatry (adult), Psychiatry (child and adolescent)” to sub-section (1) and by adding the following in the Specialty/Non-Dual Members Grid:

Specialty	Number of Non-Dual Members
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000

16. The Attachments shall be amended by adding a new Attachment V and renumbering the existing Attachments. The new Attachment V shall read as follows:

**ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES**

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR’s provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Travel distance does not exceed 75 miles for at least 75% of ADULT members and does not exceed 150 miles for at least 90% of ADULT members ----- Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 14 calendar days; if urgent, within 3 business days

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Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 14 calendar days; if urgent, within 3 business days
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)*	Travel distance does not exceed 75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of members	Within 14 calendar days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 14 calendar days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support (TDMHDD Rule Chapter 1940-5-29))	Not subject to geographic access standards	Within 14 calendar days
Supported Housing	Travel distance does not exceed 60 miles for at least 75% of ADULT members and does not exceed 90 miles for at least 90% of ADULT members	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

*24 Hour Residential Treatment Substance Abuse Services may be provided by facilities licensed by the Tennessee Department of Health as Halfway House Treatment Facilities (DOH Rule Chapter 1200-8-17), Residential Detoxification Treatment Facilities (DOH Rule Chapter 1200-8-22) or Residential Rehabilitation Treatment Facilities (DOH Rule Chapter 1200-8-23). (Effective 1/1/2008, the Tennessee Department of Mental Health and Developmental Disabilities will license these facilities.)

When the above standards are not met, an acceptable Corrective Action Plan will be requested which details the CONTRACTOR's intended course of action to resolve any deficiency (ies) identified. The Bureau of TennCare will evaluate Corrective Action Plans and, at its sole discretion, determine network adequacy considering any alternate measures and documentation of unique market conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Amendment Number 20 (cont.)

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child - A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child - A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult - 19 Child - B5
Outpatient Non-MD Services	Adult - 20 Child - B6
Intensive Outpatient/ Partial Hospitalization	Adult - 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult - 15, 17 Child - A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult - 27 or 28 Child - D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child - C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult - 40 Child - E2
Crisis Stabilization	Adult - 41

17. The renumbered Attachment XII shall be deleted and replaced in its entirety.

**ATTACHMENT XII
Cost-Sharing Schedules**

**Non-Pharmacy Copayment Schedule
(unless otherwise directed by TENNCARE)**

Poverty Level	Copayment Amounts
0%-99%	\$0.00
100% - 199%	\$10.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$5.00, Physician Specialists (including Psychiatrists) \$5.00, Prescription or Refill \$5.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	\$5.00, Hospital Emergency Room (waived if admitted) \$15.00, Primary Care Provider and Community Mental Health

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	Agency Services Other Than Preventive Care \$20.00, Physician Specialists (including Psychiatrists) \$10.00, Prescription or Refill \$100.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
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The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this attachment.

18. **The renumbered Attachment XIII, Exhibit D shall be deleted and replaced in its entirety and shall read as follows:**

**ATTACHMENT XIII, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES**

Instructions for Completing Report of Essential Hospital Services

The chart for the *Report of Essential Hospital Services* required in Section 2.30.7.4 is to be prepared based on the CONTRACTOR's provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.
 - Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.
1. In the first column, "Name of Facility" indicate the complete name of the facility.
 2. In the second column, "TennCare ID" indicate the TennCare ID assigned to the facility.
 3. In the third column, "NPI" indicate the National Provider Identifier in which issued to the facility.
 4. In the fourth column, "City/Town" indicate the city or town in which the designated facility is located.
 5. In the fifth column, "County", indicate the name of the county in which this facility is located.
 6. In the sixth through the thirteenth columns indicate the status of the CONTRACTOR's relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, Center of Excellence for Children at Risk or in State Custody and Centers of Excellence for Behavioral Health. For example:
 - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an "E" in the column labeled "Neonatal".
 - If the CONTRACTOR does not have an executed provider agreement with this facility for "Neonatal", but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.
 - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled "neonatal" blank.

**ATTACHMENT XIII, EXHIBIT G
ESSENTIAL HOSPITAL SERVICES REPORT**

MCO Name:		Grand Region:	
Number of TennCare Members:		as of (date):	

Name of Facility	TennCare ID	NPI	City/ Town	County	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Center of Excellence for Children at Risk or in State Custody	Center of Excellence for Behavioral Health	Comments

- E = Executed Provider Agreement
- L = Letter of Intent
- R = On Referral Basis
- N = In Contract Negotiations
- O = Other Arrangement

If no relationship for a particular service leave cell blank

19. The renumbered Attachment XIII shall be amended by adding new Exhibits O, P and Q which shall read as follows:

**ATTACHMENT XIII, EXHIBIT O
MENTAL HEALTH CASE MANAGEMENT REPORT**

The *Mental Health Case Management Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for appointments scheduled within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility
3. Number and percentage of compliance for appointments occurring within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility, excluding member no shows, reschedules, and refusals
4. Number and percentage of appointment no shows
5. Number and percentage of appointment reschedules
6. Number and percentage of members meeting medical necessity for mental health case management and refusing the service
7. Data elements #2 - #6 broken down by mental health case management agency
8. DCS status

**ATTACHMENT XIII, EXHIBIT P
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT**

The *Behavioral Health Crisis Response Report* required in Section 2.30.4.4 shall include, at a minimum, the following data elements:

1. Total Telephone Contacts
2. Type of Call: Psychiatric Emergency
3. Type of Call: Urgent
4. Type of Call: Routine
5. Total Face-to-Face Contacts
6. Face-to-Face Type: Psychiatric Emergency
7. Face-to-Face Type: Urgent
8. Face-to-Face Type: Routine
9. Total Face-to-Face Contacts by Payor
10. Face-to-Face Payor Source: TennCare
11. Face-to-Face Payor Source: Medicare
12. Face-to-Face Payor Source: Commercial
13. Face-to-Face Payor Source: None
14. Total Face-to-Face Contacts by Location
15. Face-to-Face Location: Onsite at CMHA
16. Face-to-Face Location: ER
17. Face-to-Face Location: Other Offsite
18. Total Face-to-Face Contacts by Disposition
19. Disposition: Total Admitted to RMHI (acute)
20. # Admitted to RMHI Not Mandatory Pre-Screened
21. Disposition: Total Admitted to Other Inpt (acute) Includes Dual Dx
22. # Admitted To Other Inpt Not Mandatory Pre-Screened
23. GRAND TOTAL PSYCHIATRIC ADMISSIONS
24. Disposition: Admitted to IP SA Treatment
25. Disposition: Referred to Lower Level OP Care
26. Disposition: Referred to Respite Services
27. Average time for Admission to Crisis Respite (only when admitted to respite)
28. Disposition: Referred to Other Services

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29. Disposition: Assessed / No Need for Referral
30. Disposition: Consumers Refusing Referral
31. Total Number of Face-to-Face Contacts for C&A <18 yrs of age
32. Total Number of Face-to-Face Contacts for C&A 18 to <21 yrs of age
33. Total Number of Face-to-Face Contacts for Adults 21 yrs and older
34. Total Number of Behavioral Health Providers notified of Crisis (only if consumer has a provider)
35. Average Time of Arrival in Minutes: Psychiatric Emergency
36. Average Time of Arrival in Minutes: Urgent
37. Barriers to Diversion: No Psychiatric Respite Accessible
38. Barriers to Diversion: No SA/Dual Respite Accessible
39. Barriers to Diversion: Consumer/Guardian Refused Respite
40. Barriers to Diversion: 6-404 Signed Prior to Assessment (when consumer could have been diverted if CON not signed)
41. Barriers to Diversion: Lack of Linkage w/Case Mgr (only if consumer has a CM)
42. Barriers to Diversion: Other (only for inappropriate admissions and barrier does not fit in any other category)

**ATTACHMENT XIII, EXHIBIT Q
MEMBER CRG/TPG ASSESSMENT REPORT**

The *Member CRG/TPG Assessment Report* required in Section 2.30.4.5 shall include, at a minimum, the following data elements:

CRG assessment of members age 18 years or older

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's birth date
5. Member's Social Security Number (SSN)
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Measure of member's level of functioning in activities of daily living
9. Measure of member's level of functioning in interpersonal functioning
10. Measure of member's level of functioning in concentration, task performance, and pace
11. Measure of member's level of functioning in adaptation to change
12. Measure of member's severity of impairment
13. Measure of member's duration of mental illness
14. Indicator of member's former severe impairment
15. Member's need for services to prevent relapse
16. Member's Clinically Related Group (CRG)
17. Reason for assessment
18. Date of request for assessment
19. Date of CRG assessment
20. Measure of rater's adequacy of information in order to complete assessment
21. Member's current Global Assessment of Functioning (GAF) scale score.
22. Member's highest GAF scale score (past year)
23. Member's lowest GAF scale score (past year)
24. Program code
25. Rater's TennCare provider ID number

TPG assessment of members under age 18

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's date of birth
5. Member's social security number

Amendment Number 20 (cont.)

6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Member's current Global Assessment of Functioning (GAF) scale score
9. Member's highest GAF scale score (past year)
10. Member's lowest GAF scale score (past year)
11. Severity of impairment
12. Serious Emotional Disturbance (SED) status
13. Environmental issues
14. Family issues
15. Trauma issues
16. Social skills issues
17. Abuse/neglect issues
18. Child at risk of SED
19. Member's Target Population Group (TPG)
20. Reason for assessment
21. Date of request for assessment
22. Date of TPG assessment
23. Measure of rater's adequacy of information in order to complete assessment
24. Program code
25. Rater's TennCare provider ID number

- 20. The Attachments shall be amended by adding new Attachments XV and XVI which shall read as follows:**

**ATTACHMENT XV
PERFORMANCE STANDARDS**

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
1	Timely Claims Processing	Report from TDCI	90% of claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of claims are processed within sixty (60) calendar days.	Percentage of claims paid within 30 calendar days of receipt of claim, for each month Percentage of claims processed within 60 calendar days of receipt of claim, for each month	Monthly	\$10,000 for each month determined not to be in compliance
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately; for each month	Monthly	\$5,000 for each full percentage point accuracy is below 97% for each month
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness - Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
5	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month
6	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
7	Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	100% of providers on the Provider Enrollment File have a signed provider agreement with the CONTRACTOR		Upon TENNCARE request	\$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Specialist Provider Network	Provider Enrollment File	<p><u>1. Physician Specialists:</u> Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology</p> <p><u>2. Essential Hospital Services:</u> Executed contract with at least one (1) tertiary care center for each essential hospital service</p> <p><u>3. Center of Excellence for People with AIDS:</u> Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s)</p> <p><u>4. Center of Excellence for Behavioral Health:</u> Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)</p>	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Monthly	<p>\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis</p> <p>The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to \$5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE</p>

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
9	Provider Participation Accuracy	Provider Enrollment File	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Quarterly	\$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers in the sample are participating
10	Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of listed providers is incorrect for <u>each</u> data element	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for <u>each</u> element as determined by TENNCARE	Quarterly	\$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for <u>each</u> data element \$25,000 per quarter if data for more than 30% of providers is incorrect for <u>each</u> data element The \$25,000 liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
11	Distance from provider to member	Provider Enrollment File	In accordance with this Agreement, including Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE
12	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	\$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment V
13	Percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment)	Claims and encounter data	The percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment) will not be less than 76%	The number of SPMI/SED members receiving a behavioral health service (excluding a CRG/TPG assessment) during the fiscal year divided by the MCO's number of SPMI/SED members during the fiscal year is not less than the benchmark	Annually	\$25,000 for each year determined to not be in compliance
14	Non-IMD Inpatient Use	Behavioral Health Crisis Service Response Reports and utilization data	10% decrease of total inpatient days at freestanding psychiatric hospitals subject to IMD exclusion compared to the base year's utilization	Total inpatient psychiatric hospital days at IMD exclusion facilities for members reduced by 10% after base line year	Annually	\$10,000 for each year determined to not be in compliance

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
15	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Quarterly	\$5,000 for each full percentage point TENNderCare screening ratio is below 80% for the most recent rolling twelve month period
16	Increase in utilization of supported employment	Supported Employment Reports	15% of all adults (21 – 64 years of age) designated as SPMI actively receiving supported employment services will be gainfully employed in either part time or full time capacity for a continuous 90 day period within one (1) year of receiving supported employment services	Total number of SPMI adults receiving supported employment services as defined in Attachment I employed for a continuous 90-day period within one (1) year of receiving supported employment services divided by the total number of SPMI adults	Annually	\$25,000 for each year determined to not be in compliance
17	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	\$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60%
18	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health case management service	Mental Health Case Management Report.	90% of discharged members receive a mental health case management service as medically necessary within seven (7) calendar days of discharge, excluding situations involving member reschedules, no shows, and refusals	(1) Number of members discharged by length of time between discharge and first subsequent mental health case management service as medically necessary reported by CMHA and type of service received; determined for each month (2) Average length of time between hospital discharge and first subsequent medically necessary MHCM visit reported by CMHA and type of service received excluding member reschedules, no shows, and refusals; determined for each month	Quarterly	\$3,000 for each quarter determined to not be in compliance

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
19	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly	\$1,500 for each quarter determined to not be in compliance
20	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly	\$1,500 for each quarter determined to not be in complianceIV.
21	Members are satisfied with the services they receive from behavioral health providers	Annual consumer satisfaction survey administered by TDMHDD	85% of respondents rate their experience to be fair or better	Distribution of members by satisfaction score	Annually	\$10,000 for each response below 85%

ATTACHMENT XVI
Administrative Fee Payments

I. Administrative Fee Effective July 1, 2001 through December 31, 2002

Category	Effective July 1, 2001 - June 30, 2002	Effective July 1, 2002 - December 31, 2002
Group 1.A	\$21.84 PMPM	\$22.71 PMPM
Group 1.B	\$21.84 PMPM	\$22.71 PMPM
Group 2	\$21.84 PMPM	\$22.71 PMPM
Group 3	\$13.84 PMPM	\$14.39 PMPM
Group 4	\$13.84 PMPM	\$14.39 PMPM
Group 5	\$13.84 PMPM	\$14.39 PMPM
Group 6	\$13.84 PMPM	\$14.39 PMPM

II. Administrative Fee Effective January 1, 2003:

Group 1.A, Group 1.B, and Group 2

Category	Effective January 1, 2003
Group 1.A	\$25.00 PMPM
Group 1.B	\$25.00 PMPM
Group 2	\$25.00 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

III. Administrative Fee Effective January 1, 2006:

Group 1.A, Group 1.B, and Group 2

Category	Effective January 1, 2003
Group 1.A	\$25.20 PMPM
Group 1.B	\$25.20 PMPM
Group 2	\$25.20 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Amendment Number 20 (cont.)

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.57
100,000 to 199,999 enrollees	\$11.45
200,000 to 299,999 enrollees	\$11.32
300,000 to 399,999 enrollees	\$11.20
400,000 to 499,999 enrollees	\$11.09
500,000 to 599,999 enrollees	\$10.88
600,000 to 699,999 enrollees	\$10.73
700,000 to 799,999 enrollees	\$10.58
800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

IV. Administrative Fee Effective September 1, 2009

Category	Effective September 1, 2009
Group 1.A	\$29.00 PMPM
Group 1.B	\$29.00 PMPM
Group 2	\$29.00 PMPM
Group 3	\$29.00 PMPM
Group 4	\$29.00 PMPM
Group 5	\$29.00 PMPM
Group 6	\$29.00 PMPM

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2009.

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

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____
M. D. Goetz, Jr.
Commissioner

BY: _____
Sonya Nelson
President and Chief Executive Officer

DATE: _____

DATE: _____

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: _____
M. D. Goetz, Jr.
Commissioner

BY: _____
Justin P. Wilson
Comptroller

DATE: _____

DATE: _____



GENERAL ASSEMBLY OF THE STATE OF TENNESSEE
FISCAL REVIEW COMMITTEE

320 Sixth Avenue, North – 8th Floor
NASHVILLE, TENNESSEE 37243-0057
615-741-2564

Sen. Bill Ketron, Chairman
Senators

Douglas Henry Reginald Tate
Doug Jackson Ken Yager
Paul Stanley
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Charles Curtiss, Vice-Chairman
Representatives

Harry Brooks Donna Rowland
Curtis Johnson Tony Shipley
Steve McManus Curry Todd
Mary Pruitt Eddie Yokley
Craig Fitzhugh, *ex officio*
Speaker Kent Williams, *ex officio*

MEMORANDUM

TO: The Honorable Dave Goetz, Commissioner
 Department of Finance and Administration

FROM: Bill Ketron, Chairman, Fiscal Review Committee
 Charles Curtiss, Vice-Chairman, Fiscal Review Committee

DATE: February 27, 2009

SUBJECT: Contract Comments
 (Fiscal Review Committee Meeting 2/23/09)

BK
CC

RFS# 318.66-026

Department: Finance & Administration/Bureau of TennCare

Contractor: Volunteer State Health Plan, Inc. (TennCare Select)

Summary: This vendor is responsible for the provision of TennCare covered services to children in state custody and provides a safety net for other TennCare MCOs statewide. The proposed amendment adds shared-risk components including EPSDT compliance increases, medical services budget targets, and performance bonuses under the shared-risk initiative.

Maximum liability: \$982,177,036

Maximum liability w/amendment: \$982,177,036

After review, the Fiscal Review Committee voted to recommend approval of the contract amendment.

cc: Mr. Darin Gordon, Deputy Commissioner
 Mr. Robert Barlow, Director, Office of Contracts Review



STATE OF TENNESSEE
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

January 27, 2009

RECEIVED

JAN 30 2009

FISCAL REVIEW

Mr. Jim White, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Bureau of TennCare Contract Amendments
Thomson Reuters (Healthcare), Inc. (formerly The Medstat Group, Inc.) – Amendment #3
Electronic Data Systems, LLC – Amendment #8
Volunteer State Health Plan, Inc. (TennCare Select) Amendment #19

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee, amendment #3 to Thomson Reuters (Healthcare), Inc. (formerly The Medstat Group, Inc.), the contractor identified to provide decision support services for the TennCare Program including Fraud and Abuse Detection and Investigation services. In an effort to reduce contractual obligations due to statewide revenue shortfalls in FY '09, TennCare is amending the contract to implement reduction in scope of services as well as renegotiated rates at a cost savings to the state.

The Bureau of TennCare is also submitting amendment #8 to Electronic Data Systems, LLC (EDS). EDS is a competitively bid contract that developed, implemented and replaced the TennCare Management Information System (TCMIS) and is currently working to transition a new contractor in place to assume TCMIS management. TennCare needs EDS to continue in their transition role for an additional three months to totally allow for complete transition, ensuring that claims management service is not interrupted. This amendment extends the term for three months to allow the new contractor to assume all duties associated with TCMIS services, as well as provides funding to support this extension. TennCare will not experience a period where the incumbent vendor and the winning bidder are simultaneously paid to operate the MMIS.

Also submitted for review by TennCare is amendment #19 to Volunteer State Health Plan, Inc. (TennCare Select.) This contractor is the managed care organization that provides TennCare covered services to children in state custody as well as other high risk enrollees and provides a safety net should other MCOs fail. This amendment provides for shared risk for the contractor, payment for performance measures, including EPSDT, Case Manager assignment, and also establishes a bonus pool for shared risk initiative. The establishment of partial risk arrangements with managed care entities allows the state to claim a more favorable federal matching rate as well as properly align incentives between the State and the managed care entity.

January 27, 2009
Mr. Jim White
Fiscal Review Committee
Page 2

The Bureau of TennCare would greatly appreciate the consideration and approval of these amendments by the Fiscal Review Committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Pierce", with a long horizontal flourish extending to the right.

Scott Pierce
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Contract Coordinator

TennCare / VSHP amendment #19

Heard and approved by Fiscal Review on 2-23-2009

I. Benefit from picking up FMAP instead of Administrative matching rate

A. FY 2010 Budgeted amount for TennCare Select Admin (at Admin match rate)

Total Expenditures	\$	30,874,000
State Appropriations	\$	15,437,000
Federal Funds	\$	15,437,000

B. FY 2010 Budgeted amount for TennCare Select Admin (at Stimulus FMAP match rate)

Total Expenditures	\$	30,874,000
State Appropriations	\$	8,119,900
Federal Funds	\$	22,754,100

State dollars saved \$ **7,317,100**

II. Benefit from VSHP hitting Budget Target incentive

Assuming VSHP hits the maximum incentive possible: 5% of admin fee due to MSBT = <85%

Incentive payment to VSHP (state dollars)	\$	(772,000)
Est. Savings from Spending being 85% of historical Medical spending (state dollars)	\$	15,032,600
State dollars saved	\$	14,260,600

Note: This assumes that VSHP would hit the maximum incentive range on the Medical Services Budget target. This is a speculative calculation because it is very possible that the maximum is not achieved. Obviously, no incentive is paid unless VSHP beats historical spending levels.

Total Possible Savings from Amendment #19 \$ **21,577,700**

III. Use of Savings

TennCare is going to budget the enhanced matching funds (\$7.3 million) into its FY 2010 budget recommendation in order to avoid reductions to services.

TennCare will not budget any savings from the Budget Target incentive, given the speculative nature of the savings. While we hope that savings materialize, it would be poor budget practice to assume that they will materialize.

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FEB 25 2009

FISCAL REVIEW

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-19
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

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APR 03 2009

FISCAL REVIEW

Service Description
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medical Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2009

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00
Total:	\$ 426,390,720.35	\$ 555,786,585.55			\$982,177,305.90

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
-------	--	--

State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	6/30/2008	6/30/2009
FY: 2002	\$ 18,599,868.48	
FY: 2003	\$ 33,079,942.80	
FY: 2004	\$ 63,490,156.62	
FY: 2005	\$116,014,894.00	
FY: 2006	\$175,496,222.00	
FY: 2007	\$175,151,878.00	
FY: 2008	\$200,000,000.00	
FY: 2009	\$200,000,000.00	
Total:	\$982,177,305.90	

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

RECEIVED

2009 MAR -6 PM 3:34

COMPTROLLER'S OFFICE OF FINANCE & ADMINISTRATION

AMENDMENT NUMBER 19

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 5-1 shall be amended by adding a new Section 5-1.k which shall read as follows:

k. **Shared Risk Terms and Conditions**

Effective March 1, 2009, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The shared risk terms shall apply to the following populations as described in Section 4-1.1.a of this Contract: Group 1.A, Group 1.B, and Group 2.

The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits. Additionally, there will be both an upside potential (bonus) as well as downside potential (risk). Bonus and the risk will be based on the following components as described below:

EPSDT, and
Medical Services Budget Target.

(1) **Acuity Adjustment**

The parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology recommended by the State or its actuarial contractor.

The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population described above. As an integral part of evaluating the CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population described above. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population described above and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

(2) **Mandates / Initiatives**

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Contract as they are performed and interpreted as of March 1, 2009. As such, services provided as a result of

compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Contract as of March 1, 2009 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

(3) Risk Component

The Shared Risk Model will require that a percent of the administrative fees be placed at risk. The Model will set ten percent (10%) of the administrative fee at risk.

The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
EPSDT Compliance	5.0%
Medical Services Budget Target	5.0%

(a) Increase EPSDT Compliance

The target for the period March 1, 2009 through June 30, 2009 is based on the CONTRACTOR's reported screening rate according to the information contained in the CMS 416 Report for FFY 2007 which is 85%.

The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Contract.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	Administrative Fee Adjustment
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annually with a 90 day lag

At Risk Portion: 5.0% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

(b) Medical Services Budget Target Initiative

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The estimated IBNR shall be reviewed and adjusted by the State's actuarial contractor prior to

final determination of performance. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag

At Risk Portion: 5% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

(4) Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative described below. The bonus pool will represent a total of ten percent (10%) of the administrative fee for the selected population (Group 1.A, Group 1.B, and Group 2) for the CONTRACTOR as described in Section 5-1 of this Contract. The following Initiatives will be included in the Bonus Pool: EPSDT Compliance and Medical Service Budget Target (MSBT).

The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus (% of Admin Rate for Selected Population)
EPSDT Compliance	5.0%
Medical Service Budget Target	5.0%

Additional Bonus Points

Performance— Percent Exceeding Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%
> 105% and ≤ 110%	60%
> 110% and ≤ 117%	100%

Performance— Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

(5) Risk and Bonus Payout Reconciliation

The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Payouts for the annual evaluation period shall be made by October 31 of the following year.

In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.

If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

2. Section 6 shall be amended by adding a new Section 6.29 which shall read as follows:

6-29 Voluntary Buyout Program

The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.

- a. The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.
- b. The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.
- c. With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Contract, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

Amendment 19 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective March 1, 2009.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M D Goetz, Jr. / sd
M. D. Goetz, Jr.
Commissioner
DATE: 2/25/09

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Sonya Nelson
Sonya Nelson
President and Chief Executive Officer
DATE: Pres. + CEO

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner
DATE: 3/10/09

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller
DATE: 3/10/09