

CONTRACT #3
RFS # 318.66-051
FA # 07-16937

Finance & Administration
Bureau of TennCare

VENDOR:
UnitedHealthCare Plan of the
River Valley, Inc.
(AmeriChoice - Middle
Tennessee Region)



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

May 18, 2010

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

RECEIVED
MAY 18 2010
FISCAL REVIEW

Attention: Ms. Leni Chick

RE: Bureau of TennCare Contract Amendments

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee the Middle Tennessee and TennCare Select managed care contract amendments which address the following changes: (1) Include language relating to enforcement of maintenance effort requirements of the Annual Coverage Assessment Act of 2010; (2) Implement rate methodology for adjusting Long-Term Care (LTC) rates based on member movement; (3) Clarify Long Term Care reporting requirements; (4) Update acceptable claims processing entities; and (5) various housekeeping clarifications including numbering and typos. There is no term extension or additional funding associated with these amendments.

Volunteer State Health Plan (Select)
AMERIGROUP Tennessee, Inc.
UnitedHealthCare Plan of River Valley, Inc.

FA-02-14632-23
FA-07-16936-06
FA-07-16937-06 ✓

The following amendments for the East/West Regions of the State include the same language as noted above with added LTC capitation payment rates for use upon implementation of the CHOICES Program in East and West TN.

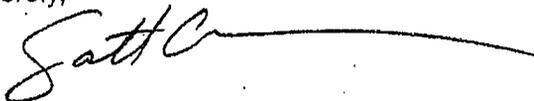
UnitedHealthCare Plan of the River Valley, Inc. (West Region)	FA-08-24979-03
Volunteer State Health Plan (West Region)	FA-08-24978-03
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-03
Volunteer State Health Plan (East Region)	FA-08-24983-03

TennCare is also submitting for Committee review amendment #1 to SXC Health Solutions, Inc., TennCare's contract for Pharmacy Management. This amendment addresses language changes associated with TennCare's e-Prescribe Initiatives, adds Disclosure of Ownership language as required by the Center for Medicare and Medicaid Services, and clarifies Liquidated Damages as currently stated in the contract.

Mr. Jim White, Director
Fiscal Review Committee
May 18, 2010

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", followed by a long horizontal line extending to the right.

Scott Pierce
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Director of Contracts

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	615-507-6415		
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051		
Edison Contract Number: (if applicable)	N/A	Edison RFS Number: (if applicable)	N/A		
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	June 30, 2011		
Current Request Amendment Number: (if applicable)	6				
Proposed Amendment Effective Date: (if applicable)	July 1, 2010				
*Department Submitting:	Department of Finance and Administration				
*Division:	Bureau of TennCare				
*Date Submitted:	May 18, 2010				
*Submitted Within Sixty (60) days:	No				
If not, explain:	Could not submit amendment until Legislature voted to approve Annual Coverage Assessment Act of 2010 that requires TennCare MCO's be amended with effective date July 1, 2010.				
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)				
*Current Maximum Liability:	\$3,345,949,706.00				
*Current Contract Allocation by Fiscal Year: (as Shown on Most Current Fully Executed Contract Summary Sheet)					
FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY
\$174,870,888	\$699,483,574	\$699,483,574	\$782,905,835	\$989,205,835	\$
*Current Total Expenditures by Fiscal Year of Contract: (attach backup documentation from STARS or FDAS report)					
FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY	FY
\$ 108,816,203.00	\$526,120,392.00	\$ 573,634,106.00	\$658,400,386.62	\$	\$
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:			The reason that allocations for the full-risk Managed Care Contractor contract exceeds the contract expenditures are that the contract maximum liability must be estimated before the first year of the contract using current enrollment and medical/behavioral claims cost. If the program's enrollment were to vary significantly from the original estimate, allocation could be higher than actual expenditures.		
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:			If the amount spent on this contract is less than the budgeted amount and contributes to a net surplus for the bureau, surplus funds would be carried forward subject to authority granted in Section 48, Item 3 of the General Appropriations Act.		

Supplemental Documentation Required for Fiscal Review Committee

IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage.		N/A	
*Contract Funding Source/Amount:	State:	\$1,057,925,836.00	Federal: \$2,288,023,870.00
Interdepartmental:			Other:
If "other" please define:			
Dates of All Previous Amendments or Revisions: (if applicable)		Brief Description of Actions in Previous Amendments or Revisions: (if applicable)	
Amendment #1 – 1/1/2007		Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants	
Amendment #2 – 7/1/2007		Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.	
Amendment #3 – 4/1/2008		Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.	
Amendment #4 – 09/01/2009		Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.	
Amendment #5 – March 1, 2010		Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.	
Method of Original Award: (if applicable)		RFP	
*What were the projected costs of the service for the entire term of the contract prior to contract award?		The costs associated with this contract were predicated on the cost proposals submitted in response to the RFP. These documents are public information and available upon request.	

Supplemental Documentation Required for Fiscal Review Committee

For all new non-competitive contracts and any contract amendment that changes Sections A or C.3. of the original or previously amended contract document, provide estimates based on information provided the Department by the vendor for determination of contract maximum liability. Add rows as necessary to provide all information requested.

If it is determined that the question is not applicable to your contract document attach detailed explanation as to why that determination was made.

Planned expenditures by fiscal year by deliverable. Add rows as necessary to indicate all estimated contract expenditures.

Actual expenditures are based on full-risk capitation rates incorporated into the contract. (Attached).

Deliverable description	FY	FY	FY	FY	FY

Proposed savings to be realized per fiscal year by entering into this contract. If amendment to an existing contract, please indicate the proposed savings to be realized by the amendment. Add rows as necessary to define all potential savings per deliverable.

This contract represents the Bureau of TennCare's competitively awarded procurement of medical and behavioral services for TennCare members through a full risk capitation payment. The contract itself does not identify savings, however, the full-risk insurance model encourages contractors to deliver all required covered benefits in a cost efficient manner by putting risk on contractor and not the state.

Deliverable description	FY	FY	FY	FY	FY

Comparison of cost per fiscal year of obtaining this service through the proposed contract or amendment vs. other options. List other options available (including other vendors), cost of other options, and source of information for comparison of other options (e.g. catalog, Web site). Add rows as necessary to indicate price differentials between contract deliverables.

This contract was competitively procured and, as such, the rates paid for the various physical and behavioral health services provided through this contract were determined as result of the Request for Proposal (RFP) process. No other options are applicable.

AMERICHoice – Middle

FY 2010

Vendor Invoice	Invoice Date	Voucher	TCS	18A	Total
			BHO PAYMENTS	MCO PAYMENTS	
AMERICHoice MIDDLE (031)					
RA100650630	6/29/2009	100650630		44,878,431.47	
RA100650633	6/29/2009	100650633	4,890,269.85		
RA100686183	8/4/2009	100686183		43,511,135.30	
RA100686186	8/4/2009	100686186	6,752,286.18		
RA100714797	9/1/2009	100714797	6,463,994.29		
RA100714794	9/1/2009	100714794		42,681,316.13	
Subtotal:			18,106,550.32	131,070,882.90	149,177,433.22

Edison Payments:

Americhoice Middle (031)					
31865	00006784	100741321	Americhoice	48,582,237.33	10/5/2009
31865	00006787	100741324	Americhoice	6,193,643.53	10/5/2009
31865	00015655	100776112	Americhoice	44,267,315.17	11/6/2009
31865	00015658	100776115	Americhoice	5,480,859.10	11/6/2009
31865	00022040	100797596	Americhoice	42,961,566.23	12/7/2009
31865	00022043	100797599	Americhoice	5,449,527.21	12/7/2009
31865	00038454	100821741	Americhoice	40,000.00	12/24/2009
Total Qtr 2				152,975,148.57	

031					
31865	00051202	100841168	Americhoice	44,449,762.28	1/7/2010
31865	00051205	100841171	Americhoice	5,997,241.10	1/7/2010
31865	00068252	100869736	Americhoice	44,025,304.75	2/4/2010
31865	00068255	100869739	Americhoice	5,514,146.11	2/4/2010
31865	00086763	100898573	Americhoice	62,590,461.23	3/4/2010
31865	00086766	100898576	Americhoice	5,701,541.32	3/4/2010
Total Qtr 3				168,278,456.79	

031					
31865	00104917	100927983	Americhoice	82,612,990.02	3/31/2010
31865	00104920	100927986	Americhoice	8,643,743.79	3/31/2010
31865	00125595	100963516	Americhoice	69,049,286.19	5/6/2010
31865	00125598	100963519	Americhoice	6,310,699.70	5/6/2010
31865	00108122	A00927983	Americhoice	21,000,580.09	3/31/2010
31865	00103799	010109-123109	Americhoice	352,048.25	4/5/2010
Total Qtr 4				187,969,348.04	

FY 2010 Total

\$658,400,386.62

100-19 PATRIC CHOICE MIDDLE

PAYMENT DATE	NET PAYMENT	NET PAYMENT	Total Capitation
6-Apr-07	30,193,652.12	5,430,628.21	35,624,280.33
4-May-07	30,721,894.62	5,360,972.80	36,082,867.42
1-Jun-07	31,906,666.23	5,202,389.69	37,109,055.92
Total 2007	92,822,212.97	15,993,990.70	108,816,203.67
2-Jul-07	37,011,638.66	6,366,817.67	43,378,456.33
1-Aug-07	35,773,103.93	5,970,399.80	41,743,503.73
4-Sep-07	40,404,514.38	6,498,725.08	46,903,239.46
5-Oct-07	40,540,348.60	6,468,428.96	47,008,777.56
2-Nov-07	33,228,076.44	5,025,243.19	38,253,319.63
7-Dec-07	37,420,468.70	5,594,292.89	43,014,761.59
4-Jan-08	37,087,078.05	5,454,825.02	42,541,903.07
1-Feb-08	40,613,916.28	5,451,570.40	46,065,486.68
7-Mar-08	37,381,759.21	5,465,284.61	42,847,043.82
4-Apr-08	37,136,982.18	5,499,941.03	42,636,923.21
2-May-08	36,940,920.21	5,438,121.33	42,379,041.54
6-Jun-08	47,269,283.53	2,078,652.82	49,347,936.35
Total 2008	460,808,090.17	65,312,302.80	526,120,392.97
1-Jul-08	40,605,157.30	3,774,763.34	44,379,920.64
30-Jul-08	42,730,129.87	5,405,192.41	48,135,322.28
3-Sep-08	42,767,588.09	5,187,203.36	47,954,791.45
3-Oct-08	44,172,210.27	5,567,452.59	49,739,662.86
4-Nov-08	44,156,027.18	5,138,714.33	49,294,741.51
5-Dec-08	42,743,793.20	5,063,075.96	47,806,869.16
1-Jan-09	42,525,614.26	4,122,295.88	46,647,910.14
3-Feb-09	42,784,950.71	4,063,624.08	46,848,574.79
6-Mar-09	43,214,522.60	4,115,450.13	47,329,972.73
1-Apr-09	43,077,357.48	4,241,850.13	47,319,207.61
28-Apr-09	43,307,855.18	4,589,613.88	47,897,469.06
2-Jun-09	44,477,413.45	5,802,251.12	50,279,664.57
Total 2009	516,562,619.59	57,071,487.21	573,634,106.80

ATTACHMENT X

**CAPITATION RATES
EFFECTIVE APRIL 1, 2007 THROUGH JUNE 30, 2008**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related)	Age Under 1	\$ 431.76
	Age 1 - 13	\$ 75.52
	Age 14 - 20 Female	\$ 207.32
	Age 14 - 20 Male	\$ 96.29
	Age 21 - 44 Female	\$ 327.13
	Age 21 - 44 Male	\$ 283.06
	Age 45 - 64	\$ 547.63
	Age 65+	\$ 306.81
Uninsured/Uninsurable	Age Under 1*	\$ 431.76
	Age 1 - 13	\$ 64.99
	Age 14 - 19 Female	\$ 105.69
	Age 14 - 19 Male	\$ 90.59
Disabled	Age <21	\$ 574.14
	Age 21+	\$ 648.55
Medicaid/Medicare Duals	All Ages	\$ 67.82
Waiver/Medicare Duals	All Ages	\$ 18.11
State Only & Judicials	All Ages	\$ 451.54
Priority Add-On	Age <21	\$ 384.28
	Age 21+	\$ 474.73

Amendment Number 5 (cont.)

- 125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".
- 126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".
- 127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

**EXHIBIT C
CAPITATION RATES
EFFECTIVE July 1, 2008 – June 30, 2009**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$ 564.71
	Age 1 - 13	\$ 87.01
	Age 14 - 20 Female	\$ 186.21
	Age 14 - 20 Male	\$ 96.93
	Age 21 - 44 Female	\$ 317.51
	Age 21 - 44 Male	\$ 174.03
	Age 45 - 64	\$ 343.00
	Age 65 +	\$ 354.29
Uninsured/Uninsurable	Age Under 1	\$ 564.71
	Age 1 - 13	\$ 65.49
	Age 14 - 19 Female	\$ 97.91
	Age 14 - 19 Male	\$ 74.66
Disabled	Age < 21	\$ 732.18
	Age 21 +	\$ 735.43
Duals/Waiver Duals	All Ages	\$ 214.22
State Only & Judicials	All Ages	\$ 557.42
Priority Add-On	Age < 21	\$ 354.55
	Age 21 +	\$ 354.55

**EXHIBIT D
CAPITATION RATES
EFFECTIVE July 1, 2009 (Except CHOICES Rates as described below)**

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	\$ 523.22
	Age 1 - 13	\$ 85.08
	Age 14 - 20 Female	\$ 230.84
	Age 14 - 20 Male	\$ 126.19
	Age 21 - 44 Female	\$ 377.73
	Age 21 - 44 Male	\$ 241.56
	Age 45 - 64	\$ 451.29
	Age 65 +	\$ 440.92
Uninsured/Uninsurable	Age Under 1	\$ 523.22
	Age 1 - 13	\$ 77.48
	Age 14 - 19 Female	\$ 107.50
	Age 14 - 19 Male	\$ 97.40
Disabled	Age < 21	\$1,433.96
	Age 21 +	\$ 944.45
Duals/Waiver Duals	All Ages	\$ 183.80
Priority Add-On	Age < 21	\$ 386.66
	Age 21 +	\$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	\$4,281.62
	CHOICES Non-Duals	\$5,625.27

128. All references throughout the Agreement to the "Division of Mental Retardation Services (DMRS)" shall be deleted and replaced with the reference "Division of Intellectual Disabilities Services (DIDS)".

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED

Commissioner of Finance & Administration

Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.

1) RFS #	318.66-051		
2) State Agency Name :	Department of Finance and Administration, Bureau of TennCare		
EXISTING CONTRACT INFORMATION			
3) Service Caption :	Provision of Physical and Behavioral Health Services to TennCare Enrollees in the Middle Tennessee Region		
4) Contractor :	United HealthCare Plan of the River Valley, Inc.		
5) Contract #	FA-07-16937-00		
6) Contract Start Date :	August 15, 2006		
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	June 30, 2011		
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	\$3,345,949,706.00		
PROPOSED AMENDMENT INFORMATION			
9) Proposed Amendment #	6		
10) Proposed Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	July 1, 2010		
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	June 30, 2011		
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	\$3,345,949,706.00		
13) 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	
14) Description of the Proposed Amendment Effects & Any Additional Service:			
<p>This competitively procured contract is being amended to address the following language changes: (1) Include language relating to enforcement of maintenance effort requirements of the Annual Coverage Assessment Act of 2010; (2) Implement rate methodology for adjusting Long-Term Care (LTC) rates based on member movement; (3) Clarify Long Term Care reporting requirements; (4) Update acceptable claims processing entities; and (5) various housekeeping clarifications including numbering and typos. There is no term extension or additional funding associated with this amendment.</p>			

15) Explanation of Need for the Proposed Amendment :

This amendment is needed to provide language changes relating to enforcement of maintenance effort requirements of the Annual Coverage Assessment Act of 2010 and to update Long Term Care reporting within the contract , as well as other contract updates.

16) Name & Address of Contractor's Current Principal Owner(s) :
(not required if proposed contractor is a state education institution)

Richard L. Bartsh, M.D.
President
United Healthcare Plan of River Valley, Inc.
1300 River Drive
Moline, IL 61265

17) Documentation of Office for Information Resources Endorsement :
(required only if the subject service involves information technology)

select one: Documentation Not Applicable to this Request Documentation Attached to this Request

18) Documentation of Department of Personnel Endorsement :
(required only if the subject service involves training for state employees)

select one: Documentation Not Applicable to this Request Documentation Attached to this Request

19) Documentation of State Architect Endorsement :
(required only if the subject service involves construction or real property related services)

select one: Documentation Not Applicable to this Request Documentation Attached to this Request

20) Description of Procuring Agency Efforts to Identify Reasonable, Competitive Procurement Alternatives :

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region. This amendment adds language changes and clarifications to the existing competitively procured contract. This amendment does not include additional funding.

21) Justification for the Proposed Non-Competitive Amendment

This competitively procured contract is being amended to update requirements for the Long-Term Care Community Choices Act of 2008, as well as the Annual Coverage Assessment Act of 2010. The Bureau of TennCare feels this amendment represents necessary changes to comply with State law and that also strengthens the contract and assures state and federal compliance. The approval by the Commissioner of Finance and Administration is greatly appreciated.

REQUESTING AGENCY HEAD SIGNATURE & DATE :

(must be signed & dated 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)



5/10/10

Agency Head Signature

Date

CONTRACT SUMMARY SHEET

021406

CONTRACT NOT PAID THROUGH EDISON

RFS #	Contract #
318.66-051	FA-07-16937-06
State Agency	State Agency Division
Department of Finance and Administration	Bureau of TennCare
Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	<input type="checkbox"/> C- or <input checked="" type="checkbox"/> V- 363379945 01

Service Description			
Provision of Physical and Behavioral Health Services to TennCare Enrollees in the Middle Tennessee Region			
Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	June 30, 2011	subrecipient	93.778 Dept. of Health and Human Services/Title XIX

Mark Each TRUE Statement

<input type="checkbox"/> Contractor is on STARS	<input type="checkbox"/> Contractor's Form W-9 is on file in Accounts
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Allocation Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
318.66	4M9	134	11		
FY	State	Federal	Intra-departmental	Other	TOTAL Contract Amount
2007	\$ 63,416,928.00	\$ 111,453,960.00			\$ 174,870,888.00
2008	\$ 253,667,718.00	\$ 445,815,856.00			\$ 699,483,574.00
2009	\$253,667,718.00	\$445,815,856.00			\$ 699,483,574.00
2010	\$195,060,989.00	\$587,844,846.00			\$ 782,905,835.00
2011	\$ 292,112,483.00	\$ 697,093,352.00			\$ 989,205,835.00
					\$ -
TOTAL	\$ 1,057,925,836.00	\$ 2,288,023,870.00	\$ -	\$ -	\$ 3,345,949,706.00

COMPLETE FOR AMENDMENTS ONLY			State Agency Fiscal Contact & Telephone #
FY	Base Contract & Prior Amendments	THIS Amendment ONLY	
2007	\$174,870,888.00		Scott Pierce 507-6415
2008	\$ 699,483,574.00		
2009	\$ 699,483,574.00		
2010	\$ 782,905,835.00		
2011	\$ 989,205,835.00		
		\$ -	
TOTAL	\$ 3,345,949,706.00	\$ -	
End Date	June 30, 2011	June 30, 2011	

Contractor Ownership (complete only for base contracts with contract # prefix FA or CR)

<input type="checkbox"/> African American	<input type="checkbox"/> Person w/ Disability	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Small Business	<input checked="" type="checkbox"/> NOT disadvantaged
<input type="checkbox"/> Asian	<input type="checkbox"/> Female	<input type="checkbox"/> Native American	<input type="checkbox"/> OTHER minority/disadvantaged—	

Contractor Selection Method (complete for ALL base contracts - N/A for amendments or delegated authorities)

<input checked="" type="checkbox"/> RFP	<input type="checkbox"/> Competitive Negotiation	<input type="checkbox"/> Alternative Competitive Method
<input type="checkbox"/> Non-Competitive Negotiation	<input type="checkbox"/> Negotiation w/ Government (eg, ID, GG, GU)	<input type="checkbox"/> Other

Procurement Process Summary (complete for Alternative Method, Competitive Negotiation, Non-Competitive Negotiation OR Other)

AMENDMENT NUMBER 6

**CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND**

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA-07-16937-00

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 Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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. **Sections 2.6.1.3, 2.6.2.3, and 2.11.1.8.2 shall be amended by deleting and replacing references to MR and/or Mental Retardation and replacing them with references to “intellectual disabilities (i.e., mental retardation).**
2. **The first sentence of Section 2.6.7.2.4 shall be amended by adding the phrase “and the member otherwise qualifies to enroll in CHOICES Group 2,” after the word “member.”**
3. **Section 2.7.2.8.1.5 shall be deleted and replaced as follows:**

2.7.2.8.1.5 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.
4. **Section 2.9.6.9.6.4.1 shall be amended by adding additional text to the end which shall read as follows:**

2.9.6.9.6.4.1 For CHOICES members in Groups 1 and 2, Freedom of Choice form signed by the member or his/her representative; this requirement shall only apply to persons age twenty-one (21) and older who may qualify to enroll in CHOICES Groups 2 or 3;
5. **Section 2.9.6.11.12.14 shall be deleted and replaced as follows:**

2.9.6.11.12.14 For members in CHOICES Groups 1 and 2, as applicable, members’ responsibility regarding patient liability, including the consequences of not paying patient liability;

6. Section 2.11.5.1 shall be deleted and replaced as follows:

2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities as appropriate, utilizing the Regional Mental Health Institutes only when no other option is available.

7. Section 2.11.8.1 shall be amended by adding a new Section 2.11.8.1.3 which shall read as follows:

2.11.8.1.3 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

8. Section 2.11.8.2 shall be amended by adding a new Section 2.11.8.2.3 which shall read as follows:

2.11.8.2.3 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

9. Section 2.12 shall be amended by adding a new Section 2.12.16 which shall read as follows:

2.12.16 The CONTRACTOR shall comply with the Annual Coverage Assessment Act of 2010, (T.C.A. 71-5-1003 *et seq.*, 71-5-1005 *et seq.*).

2.12.16.1 The CONTRACTOR shall be prohibited from implementing across the board rate reductions to covered or excluded contract hospitals or physicians either by category or type of provider. These requirements shall also apply to services or settings of care that are ancillary to a covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not apply to any other ancillary services or settings of care. For purposes of this Section, covered or excluded contract hospitals or physicians shall be those as defined by the Annual Coverage Assessment Act of 2010.

2.12.16.2 For across the board rate reductions to ancillary services or settings of care, the CONTRACTOR shall provide appropriate notice.

2.12.16.3 For purposes of this requirement, services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation or skilled nursing services. Further, for purposes of this requirement, "physician" includes a physician licensed under title 63, chapter 6 and chapter 9 and a group practice of physicians that hold a contract the CONTRACTOR.

10. Section 2.20.2.1 and 2.20.2.3 shall be deleted and replaced as follows:

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

Amendment Number 6 (cont.)

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 TENNCARE and the appropriate agency as follows:

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 TENNCARE and OIG or TBI MFCU, as appropriate.

11. Section 2.20.2 shall be amended by adding a new Section 2.20.2.10 and renumbering the remaining subsections accordingly, including any references thereto. The new Section 2.20.2.10 shall read as follows:

2.20.2.10 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

12. Section 2.21.5.2 shall be deleted and replaced as follows:

2.21.5.2 The CONTRACTOR shall delegate collection of patient liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount. For members in CHOICES Groups 2 or 3 receiving non-residential HCBS, the CONTRACTOR shall collect applicable patient liability amounts.

13. The opening paragraph in Section 2.21.9 shall be amended by adding a new third sentence so that the opening paragraph of Section 2.21.9 shall read as follows:

2.21.9 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. The CONTRACTOR shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has 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 word "contractors" in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, etc. This disclosure shall be made in accordance with the requirements in Section 2.30.15.3.2. The following information shall be disclosed:

14. Section 2.22.6.4.14 shall be deleted in its entirety and the remaining subsections shall be renumbered as appropriate, including all references thereto.

15. Section 2.26.7 shall be amended by deleting the reference to Section 2.25.9 and replacing it with the reference to Section 2.25.11.

16. Section 2.26.12.1 shall be amended by adding the words “durable medical equipment” and shall read as follows:

2.26.12.1 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, durable medical equipment 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.

17. Sections 2.30.7.6 and 2.30.7.7 shall be deleted in their entirety and the remaining subsections shall be renumbered as appropriate, including all references thereto.

18. Section 2.30.10.5 shall be deleted and replaced as follows:

2.30.10.5 The CONTRACTOR shall submit a monthly *CHOICES Utilization Report*. The report shall be submitted on a monthly basis with a one (1) month lag period (e.g., March information sent in the May report) and shall include a summary overview that includes the number of CHOICES member who have not received any long-term care services within thirty (30) to fifty-nine (59) days, within sixty (60) to eighty-nine (89) days, or in ninety (90) days or more. The report shall also include detailed member data for members who have not received services in the last thirty (30) days, including the member’s name, social security number, CHOICES group, and CHOICES enrollment date; date of last long-term care service; length of time without long-term care services; whether and when long-term care services will resume; and the reason/explanation why the member has not received long-term care services.

19. Section 2.30.14 shall be amended by adding new Sections 2.30.14.4 through 2.30.14.7 as follows:

2.30.14 Fraud and Abuse Reports

2.30.14.1 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).

2.30.14.2 The CONTRACTOR shall submit an annual fraud and abuse compliance plan (see Section 2.20.3 of this Agreement).

2.30.14.3 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.

Amendment Number 6 (cont.)

- 2.30.14.4 The CONTRACTOR shall submit an annual *Risk Assessment Report* providing results of an annual risk assessment of the CONTRACTOR's various fraud and abuse/program integrity processes. The reports shall also be submitted on an 'as needed' basis and immediately after an adverse action, including financial-related actions (such as overpayment recoupment and fines), is issued on a provider with concerns of fraud and abuse. The CONTRACTOR shall inform TENNCARE of such action and provide details of such financial action.
- 2.30.14.5 The CONTRACTOR shall submit a quarterly *Program Integrity Exception List report* that identifies employees or contractors (as defined in Section 2.21.9) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities), the CMS MED (Medicare Exclusion Database), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board. This quarterly report shall be submitted no later than the fifteenth (15th) of the month following the end of the quarter that is being reported.
- 2.30.14.6 The CONTRACTOR shall submit a monthly *List of Involuntary Terminations Report* (including providers termed due to sanctions, invalid licenses, etc.) due to fraud and abuse concerns to TENNCARE.
- 2.30.14.7 In addition to the appropriate agency as described in Section 2.20.2, the CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE immediately in accordance with Section 2.20.2.

20. Section 3.4.3.7 shall be deleted and replaced as follows:

- 3.4.3.7 For CHOICES members, only the non-long-term care component of the base capitation rate will be adjusted for health plan risk. The long-term care component of the base capitation rate will not be adjusted for health plan risk. The long-term care component of the base capitation rate will be adjusted according to the following:
 - 3.4.3.7.1 Member Movement during Implementation and/or Open Enrollment Periods
 - 3.4.3.7.1.1 TENNCARE will track CHOICES member change requests that occur from March 1st, 2010 through the completion of the 2010 open enrollment period for enrollees who were enrolled in CHOICES on March 1, 2010.
 - 3.4.3.7.1.1.1 CHOICES members that change MCOs during the open enrollment period will be designated as either a NF enrollee or an HCBS enrollee based upon the determination made in the eligibility file on the date of their official transfer.
 - 3.4.3.7.1.1.2 The net transfer of CHOICES members from March 1, 2010 through May 31, 2010 will be compared to the mix of NF/HCBS enrollees in the data book assumptions. If the mix of net transfers exceeds one half (½) of one (1) percent different between the MCOs, rates will be adjusted accordingly.
 - 3.4.3.7.1.2 A similar process will occur in May 2011, after the completion of the open enrollment period for 2011. This process will compare the effect of net transfers as compared to the mix before the 2011 open enrollment period.
 - 3.4.3.7.1.3 This adjustment will be budget neutral to the state.

Amendment Number 6 (cont.)

3.4.3.7.1.4 This adjustment described in Section 3.4.3.7.1 is intended to address changes in CHOICES member enrollment mix due to enrollees changing from one MCO to another and does not address changes in enrollment mix due to other factors.

3.4.3.7.2 New Membership

3.4.3.7.2.1 In February 2011, after each new enrollee's forty-five (45) day change period is over, TENNCARE will review the patterns of MCO enrollment for the new CHOICES members who have enrolled in the CHOICES program from March 1, 2010 until December 31, 2010.

3.4.3.7.2.1.1 In order to protect each MCO from adverse selection, TENNCARE will compare the distribution of new enrollees between MCOs to the regional averages. If the mix of net transfers exceeds one half (1/2) of one percent (1%) different between the MCOs, rates will be adjusted accordingly. This is not intended as a rebasing of the overall regional rates.

3.4.3.7.3 These two review processes described in Sections 3.4.3.7.1 and 3.4.3.7.2 are meant to assure a fair procedure to protect MCOs from adverse selection, either from members changing plans during the implementation and open enrollment periods or new members selecting one MCO over another in a disproportionate manner. The reviews are not meant to rebase the rates based upon the overall trend in the CHOICES program.

3.4.3.7.4 The CONTRACTOR and TENNCARE recognize that there may be other circumstances that warrant a rate adjustment to the long-term care component of the base capitation rates and therefore, as determined by TENNCARE, in order to maintain actuarial soundness, TENNCARE may adjust the rates accordingly.

21. Section 3.9.2.1 shall be amended by deleting the reference to Section 2.25.9 and replacing it with the reference to Section 2.25.11.

22. Section 4.3 shall be amended by adding a new Section 4.3.45 which shall read as follows:

4.3.45 TCA 71-5-1003 *et seq.*, 71-5-1005 *et seq.*

23. Section 4.20.2.2.7 shall be amended by adding new liquidated damages to Level A of the Liquidated Damages Chart as follows:

<p>A.18</p>	<p>Failure to provide continuity of care consistent with the services in place prior to the member's enrollment in the CONTRACTOR's CHOICES Program for a CHOICES member transferring from another MCO or upon CHOICES implementation in the Grand Region (see Sections 2.9.2 and 2.9.3)</p>	<p>\$500 per day beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided</p>
<p>A.19</p>	<p>Failure to complete a comprehensive assessment, develop a plan of care, and authorize and initiate all long-term care services specified in the plan of care for a CHOICES member within specified timelines (see Section 2.9.6)</p>	<p>\$500 per day for each service not initiated timely beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided</p>
<p>A.20</p>	<p>Failure to develop a person-centered plan of care for a CHOICES member that includes all of the required elements, and which has been reviewed with and signed by the member or his/her representative, unless the member/representative refuses to sign which shall be documented in writing</p>	<p>\$500 per deficient plan of care</p>

24. Section 4.32.1 shall be amended by deleting “, beliefs” after the word “religion”.

25. Item 4 of the CONTRACTOR requirements of “Mental Health Case Management” Service Delivery in Attachment I shall be deleted and replaced as follows:

- 4) A minimum of fifty-one (51%) of all mental health case management services should take place outside the case manager's office at the most appropriate setting;

26. Attachment III shall be amended by adding the following Section regarding “Long Term Care Services” immediately following the existing Section titled “Lab and X-Ray Services” as follows:

- Long Term Care Services:

- (a) Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for TennCare enrollees in suburban areas and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.

27. Attachment VIII shall be amended by deleting references to reports “2.30.7.6” and “2.30.7.7” and renumbering the remaining Items and references to the remaining reports of Section 2.30.7 as appropriate.

135. CHOICES Qualified Workforce Strategies Report (see Section 2.30.7.6)

136. FQHC Reports (see Section 2.30.7.7)

137. Institutions for Mental Diseases (IMD) Out-of-State Report (see Section 2.30.7.8)

28. Attachment VIII shall be amended by adding new Items 166 through 168 as follows and renumbering the remaining Items as appropriate.

166. Risk Assessment Report (see Section 2.30.14.4)

167. Program Integrity Exception List Report (see Section 2.30.14.5)

168. List of Involuntary Terminations Report (see Section 2.30.14.6)

Amendment Number 6 (cont.)

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, 2010.

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

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**UNITEDHEALTHCARE PLAN OF THE
RIVER VALLEY, INC.**

BY: _____
M. D. Goetz, Jr.
Commissioner

BY: _____
Scott A. Bowers
Chief Executive Officer, TennCare

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
Brian Kelsey
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: January 26, 2010

SUBJECT: Contract Comments
 (Fiscal Review Committee Meeting 1/25/10)

BK CC

RFS# 318.66-051

Department: Finance & Administration/Bureau of TennCare

Contractor: UnitedHealthCare Plan of the River Valley, Inc.,
AmeriChoice - Middle Tennessee Region

Summary: The vendor is responsible for the provision of physical and behavioral health services to TennCare enrollees in the Middle Tennessee region. The proposed amendment consolidates reporting requirements, makes revisions to better align with the West and East Tennessee MCO contracts, and increases the maximum liability by \$989,205,835.

Maximum liability: \$2,356,743,871

Maximum liability w/amendment: \$3,345,949,706

After review, the Fiscal Review Committee voted to recommend approval of the contract amendment.

cc: The Honorable Darin Gordon, Deputy Commissioner
Mr. Robert Barlow, Director, Office of Contracts Review

CONTRACT SUMMARY SHEET

021406

CONTRACT NOT PAID THROUGH EDISON

318.66-051

FA-07-16937-05

Department of Finance and Administration

Bureau of TennCare

UnitedHealthCare Plan of the River Valley, Inc.

C- or X V- 369379945 01

Provision of Physical and Behavioral Health Services to TennCare Enrollees In the Middle Tennessee Region

August 15, 2008

June 30, 2011

subrecipient

93.778 Dept. of Health and Human Services/Title XIX

Contractor is on STARS

Contractor's Form W-9 is on file in Accounts

318.66

4M9

134

11

2007	\$ 63,416,928.00	\$ 111,459,980.00		\$ 174,870,888.00
2008	\$ 253,667,718.00	\$ 445,815,856.00	OCR RELEASED	\$ 699,483,574.00
2009	\$253,667,718.00	\$445,815,856.00		\$ 699,483,574.00
2010	\$195,060,989.00	\$587,844,846.00	APR 18 2010 Agency	\$ 782,905,835.00
2011	\$ 292,112,483.00	\$ 697,093,352.00	TO AGENCY	\$ 989,205,835.00
	\$ 1,057,925,838.00	\$ 2,288,028,870.00		\$ 3,345,949,706.00

Scott Pierce 507-6418

2007	\$174,870,888.00	
2008	\$ 699,483,574.00	
2009	\$ 699,483,574.00	
2010	\$ 782,905,835.00	
2011		\$ 989,205,835.00
	\$ 2,356,743,871.00	\$ 989,205,835.00
	June 30, 2010	June 30, 2011

Scott

M. S. Deth

AGS

African American Person w/ Disability Hispanic Small Business NOT disadvantaged
 Asian Female Native American OTHER minority/disadvantaged

RFP Competitive Negotiation Alternative Competitive Method
 Non-Competitive Negotiation Negotiation w/ Government (eg, ID, GC, GU) Other

OCR
MAR 09 2010
RECEIVED