CONTRACT #4
RFS # 318.66-053
FA # 08-24983-00

Finance & Administration
Bureau of TennCare

VENDOR:
Volunteer State Health Plan
East Tennessee Region

RECEIVED
JUN 29 2009
FISCAL REVIEW

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

June 29, 2009

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

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee the following Managed Care contract amendments which cover the East and West Regions of the State:

UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-01
Volunteer State Health Plan (West Region)	FA-08-24978-01
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-01
Volunteer State Health Plan (East Region)	FA-08-24983-01

These amendments address the following language changes: (1) Incorporate language to comply with the Mental Health Parity Act; (2) add clarifying language to strengthen TENNderCare Outreach activities (3) incorporate language to clarify CMS requirement for MCO and providers to screen employees and contractors to assure they have not been excluded from participation in the Medicare, Medicaid, SCHIP or any other federal program;(4) revise various quality reporting timeframes in order to streamline report review and analysis and to be consistent with various NCQA reporting requirements, change claims payment reporting timeframes from quarterly to monthly, change prompt pay reporting timeframes from quarterly to monthly, and incorporate standing On-Request reporting requirement as an ongoing contractual requirement as a mechanism to assure MCOs are reconciling provider payments with claims data; and (5) incorporate boiler plate language required in all state contracts regarding the Voluntary Buyout Program and the Federal Economic Stimulus Funding.

Additionally, TennCare is submitting for review the following Managed Care contract amendments for the Middle Region of the State.

AMERIGROUP Tennessee, Inc.	FA-07-16936-04
UnitedHealthCare Plan of River Valley, Inc.	FA-07-16937-04

In addition to the language changes specified in East/West amendments above, these amendments also add requirements to implement the Long-Term Care Community Choices Act of 2008 in the Middle Region. This Act restructures the long-term care system in Tennessee, expanding access to more cost effective home and community-based services. It incorporates LTC services into the MCO contract to create a seamless delivery system with managed care contractors responsible for all of the covered primary, acute, behavioral, and long-term care services for members who need them.

TennCare is also submitting for Committee review TennCare's contract for Dental Benefits Manager, Doral Dental of Tennessee, LLC. This proposed amendment will extend the term date of this competitively procured contract for an additional period of one year, as well as provide funding for this extension of time based on funding rates submitted in the RFP Cost Proposal. Additionally, contract language is modified relevant to prior authorization requirements, second opinions by contractor designated dentists, initiation of corrective actions, and inclusion of state required language regarding Voluntary Buy-out and Prohibition of Illegal Immigrants.

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

Sincerely,

Scott Pierce
Chief Financial Officer

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

NON-COMPETITIVE AMENDMENT REQUEST:

APPROVED
Commissioner of Finance & Administration

RECEIVED
JUN 29 2009
FISCAL REVIEW

1) RFS #	318.66-053-08
2) Procuring Agency :	Department of Finance and Administration Bureau of TennCare
EXISTING CONTRACT INFORMATON	
3) Service Caption :	Provision of Physical and Behavioral Health Services to TennCare Enrollees in the East Tennessee Region
4) Contractor :	Volunteer State Health Plan
5) Contract #	FA-08-24983-00
6) Contract Start Date :	May 19, 2008
7) CURRENT Contract End Date : (if ALL options to extend the contract are exercised)	June 30, 2010
8) CURRENT Maximum Cost : (if ALL options to extend the contract are exercised)	$ 885,708,000.00
PROPOSED AMENDMENT INFORMATON	
9) Amendment #	1
10) Amendment Effective Date : (attached explanation required if < 60 days after F&A receipt)	September 1, 2009
11) PROPOSED Contract End Date : (if ALL options to extend the contract are exercised)	June 30, 2010
12) PROPOSED Maximum Cost : (if ALL options to extend the contract are exercised)	$ 885,708,000.00

13) Approval Criteria : (select one)	x	**use of Non-Competitive Negotiation is in the best interest of the state**
	☐	**only one uniquely qualified service provider able to provide the service**

14) Description of the Proposed Amendment Effects & Any Additional Service :

This competitively procured contract is being amended to address the following language changes: (1) Incorporate language to comply with the Mental Health Parity Act; (2) add clarifying language to strengthen TENNderCare Outreach activities (3) incorporate language to clarify CMS requirement for MCO and providers to screen employees and contractors to assure they have not been excluded from participation in the Medicare, Medicaid, SCHIP or any other federal program;(4) revise various quality reporting timeframes in order to streamline report review and analysis and to be consistent with various NCQA reporting requirements, change claims payment reporting timeframes from quarterly to monthly, change prompt pay reporting timeframes from quarterly to monthly, and incorporate standing On-Request reporting requirement as an ongoing contractual requirement as a mechanism to assure MCOs are reconciling provider payments with claims data; and (5) incorporate boiler plate language required in all state contracts regarding the Voluntary Buyout Program and the Federal Economic Stimulus Funding.

15) Explanation of Need for the Proposed Amendment :

This amendment is needed to comply with Mental Health Parity Act, provide clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting

requirements, as well as provide boiler plate language required by State not effective when contract was procured and executed.

16) Name & Address of Contractor's Current Principal Owner(s) : (not required for a TN state education institution)

Sonya Nelson
President and Chief Executive Officer
Volunteer State Health Plan, Inc.
801 Pine Street
Chattanooga, Tennessee 37402-2555

17) Office for Information Resources Endorsement : (required for information technology service; n/a to THDA)

Documentation is ... x Not Applicable to this Request ☐ **Attached to this Request**

18) eHealth Initiative Endorsement : (required for health-related professional, pharmaceutical, laboratory, or imaging service)

Documentation is ... x Not Applicable to this Request ☐ **Attached to this Request**

19) Department of Human Resources Endorsement : (required for state employees training service)

Documentation is ... x Not Applicable to this Request ☐ **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 East Tennessee Region. This amendment adds language changes and clarifications to existing competitively procured contract.

21) Justification for the Proposed Non-Competitive Amendment :

The changes proposed in this amendment will result in compliance with both the Center for Medicare and Medicaid Services (CMS) requirements to screen employees and contractors to assure they have not been excluded from participation in the Medicare, Medicaid, SCHIP or any other federal program, reporting streamlines and language changes as stipulated by the State. These items represent changes that were not in place when this contract was competitively procured. The Bureau of TennCare feels this amendment represents changes that will strengthen the contract and assure state and federal compliance. The approval by the Commissioner of Finance and Administration is greatly appreciated.

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)

M. D. Goetz, Jr., Commissioner 6/25/09

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	615-607-6415
*Contract Number:	FA-08-24983-00	*RFS Number:	RFS 318.66-053-08
*Original Contract Begin Date:	May 19, 2008	*Current End Date:	June 30, 2010
Current Request Amendment Number: *(if applicable)*	#1		
Proposed Amendment Effective Date: *(if applicable)*	September 1, 2009		
*Department Submitting:	Department of Finance and Administration		
*Division:	Bureau of TennCare		
*Date Submitted:	June 29, 2009		
*Submitted Within Sixty (60) days:	Yes		
If not, explain:			
*Contract Vendor Name:	Volunteer State Health Plan (East Region)		
*Current Maximum Liability:	$885,708,000.00		

*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: 2009	FY: 2010	FY:	FY:	FY	FY
$295,236,000.00	$590,472,000.00	$	$	$	$

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from STARS or FDAS report) **Attached**

FY: 2009	FY: 2010	FY:	FY:	FY	FY
$ 328,230,257.00	$ N/A	$	$	$	$

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 Allocation, please give the reasons and explain how funding was acquired to pay the overage:	The reason that Fiscal Year expenditures for the full-risk Managed Care contract exceeds the contract allocation 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, expenditures could be higher than actual allocations, however, the expenditures do not exceed the maximum liability of the contract.

*Contract Funding Source/Amount:	State:	$252,993,634.00	Federal:	$632,714,366.00
Interdepartmental:			*Other:*	

Supplemental Documentation Required for Fiscal Review Committee

If "*other*" please define:			
Dates of All Previous Amendments or Revisions: (*if applicable*)		Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)	
N/A			
Method of Original Award: (*if applicable*)		Request for Proposal	

Pursuant to the request from the Fiscal Review Committee regarding additional information relative to contracts, the following responses are relevant to this amendment submitted to Fiscal Review 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 based on full risk capitation rates (Attached). The funding source is based on Federal Financial Participation (FFP). Due to federal stimulus dollars, Fiscal Year 2010 FFP is increased to .75085 federal and .24915 state.

(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.**

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

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

This East Region full-risk contract will save on average 5.3% when compared to traditional fee-for-service contract at an estimated savings of $88.7 million.

ATTACHMENT XII

CAPITATION RATES
EAST
EFFECTIVE January 1, 2009 through June 30, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related)	**Age Under 1**	**$ 504.49**
And	**Age 1 - 13**	**$ 94.56**
Standard Spend Down	**Age 14 - 20 Female**	**$ 204.60**
	Age 14 - 20 Male	**$ 110.31**
	Age 21 - 44 Female	**$ 302.31**
	Age 21 - 44 Male	**$ 183.37**
	Age 45 – 64	**$ 336.56**
	Age 65 +	**$ 377.99**
Uninsured/Uninsurable	**Age Under 1**	**$ 504.49**
	Age 1 - 13	**$ 81.81**
	Age 14 - 19 Female	**$ 116.99**
	Age 14 – 19 Male	**$ 87.30**
Disabled	**Age < 21**	**$ 699.07**
	Age 21 +	**$ 588.88**
Duals/ Waiver Duals	**All Ages**	**$ 107.69**
State Only & Judicials	**All Ages**	**$468.19**
Priority Add-On	**All Ages**	**$ 228.93**

MCO 027 BLUECARE EAST

PAYMENT	NET PAYMENT	NET PAYMENT	**Total Capitation**
1-Jan-09	41,949,321.67	3,854,347.47	**45,803,669.14**
3-Feb-09	51,353,117.88	4,614,834.22	**55,967,952.10**
6-Mar-09	52,188,503.48	4,523,618.42	**56,712,121.90**
1-Apr-09	51,526,060.46	4,630,223.42	**56,156,283.88**
28-Apr-09	52,346,931.28	4,226,695.63	**56,573,626.91**
2-Jun-09	52,379,941.41	4,636,662.17	**57,016,603.58**
Total 2009	**301,743,876.18**	**26,486,381.33**	**328,230,257.51**

DO NOT LOAD ON STARS
CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
318.66-053-08	FA-08-24983-01
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
Volunteer State Health Plan	☐ C- or ☒ V-

Service Description

Provision of Physical and Behavioral Health Services to TennCare Enrollees in East Tennessee Region

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
May 19, 2008	June 30, 2010	Subrecipient	93.778 Dept of Health & Human Services/Title XIX

Mark Each TRUE Statement

☐ Contractor is on STARS

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
318.66			11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2008					0.00
2009	$105,877,534.00	$189,358,466.00			$295,236,000.00
2010	$147,116,100.00	$443,355,900.00			$590,472,000.00
TOTAL:	$252,993,634.00	$632,714,366.00			**$885,708,000.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2008	0.00	0.00
2009	$295,236,000.00	0.00
2010	$590,472,000.00	0.00
TOTAL:	**$885,708,000.00**	**0.00**
End Date:	**6/30/2010**	**6/30/2010**

State Agency Fiscal Contact & Telephone #

Scott Pierce
310 Great Circle Road
Nashville, TN 37243
(615) 507-6415

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership (complete for ALL base contracts— N/A to amendments or delegated authorities)

☐ African American ☐ Person w/ Disability ☐ Hispanic ☐ Small Business ☐ Government
☐ Asian ☐ Female ☐ Native American ☒ NOT Minority/Disadvantaged ☐ Other

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

☒ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *
☐ Non-Competitive Negotiation * ☐ Negotiation w/ Government (ID, GG, GU) ☐ Other *

*** Procurement Process Summary** (complete for selection by Non-Competitive Negotiation, Competitive Negotiation, OR Alternative Method)

AMENDMENT NUMBER 1

EAST GRAND REGION
CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND

VOLUNTEER STATE HEALTH PLAN, INC.,
d.b.a. BLUECARE

CONTRACT NUMBER: FA- 08-24983-00

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 THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" or "State" and Volunteer State Health Plan, 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. Remove references to "State Onlys and Judicals" -throughout the Agreement.

2. Section 1 shall be amended by replacing "Health Plan Employer" with Healthcare Effectiveness" to read as follows:

   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.

3. Section 2.4.4.6.4 shall be amended by adding additional text to the end of the existing text:

   2.4.4.6.4 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.

4. Section 2.6.1.4 shall be deleted in its entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

5. The renumbered Section 2.6.1.4 shall be amended by adding the phrase ", unless otherwise described in the 2008 Mental Health Parity Act as determined by TennCare" to the end of the existing text in the The Benefit Limits for *Inpatient, Residential & Outpatient Substance Abuse Benefits* for the *Medicaid/Standard Eligible, Age 21 and Older* population.

6. Section 2.7.3 shall be amended by deleting Section 2.7.3.3.

7. Section 2.7.5.2.2 shall be amended by adding a new Section 2.7.5.2.2.1 and renumbering existing subparts accordingly, including any references thereto.

2.7.5.2.2.1 If the CONTRACTOR's TENNderCare screening rate is below ninety percent (90%), as determined in the most recent CMS 416 report, 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.

8. Section 2.7.5.2.5 shall be shall be amended by adding new text and shall read as follows:

2.7.5.2.5 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 shall 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 2.7.5.2.4 above.)

9. Section 2.7.5.2.7 shall be deleted in its entirety and replaced with the following:

2.7.5.2.7 The CONTRACTOR shall make and document a minimum of two (2) reasonable attempts to find a member with one (1) of the two (2) attempts being made within thirty (30) days of receipt of mail returned as undeliverable and the second being made within ninety (90) days of receipt of mail returned as undeliverable. At least one (1) of these attempts shall be by phone.

10. Section 2.7.5.2 shall be amended by adding a new Section 2.7.5.2.10.

2.7.5.2.10 The CONTRACTOR shall provide member education and outreach in community settings. Outreach events shall be conducted in the Grand Region covered by this agreement, in accordance with the following specifications:

2.7.5.2.10.1 Outreach events shall number a minimum of one hundred fifty (150) per year with no less than twenty five (25) per region, per quarter.

2.7.5.2.10.1.1 At least thirty percent (30%) shall be conducted in rural areas. Results of the CONTRACTOR's 416 report and HEDIS report, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific populations.

2.7.5.2.10.2 The CONTRACTOR shall contact a minimum of 25 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 shall be those who serve TennCare enrollees. Collaborative activities should include those designed to reach enrollees with limited English proficiency, low literacy levels, behavioral health and special healthcare needs or who are pregnant.

11. Section 2.7.7.4.2 shall be amended by adding new text to the end of the existing text.

2.7.7.4.2 The CONTRACTOR shall ensure that a "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" form, which is available on TENNCARE's web site, is completed. The form shall be available in English and Spanish, and assistance shall be provided in completing the form when an alternative form of communication is necessary.

12. Section 2.8.1.4 shall be amended by adding new text and shall read as follows:

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:

13. Section 2.8.2.1 shall be amended by deleting the last sentence so that Section 2.8.2.1 shall read as follows:

2.7.7.5 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program.

14. Section 2.8.3 shall be deleted in its entirety and replaced with the following:

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.

15. Section 2.8.4 shall be amended by adding new text and shall read as follows:

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.

16. Section 2.9.4.1.5 shall be amended by adding new text and shall read as follows:

2.9.4.1.5 Program Evaluation (Satisfaction and Effectiveness).

17. Section 2.9.4.2.1 and 2.9.4.3 shall be deleted in their entirety and the remaining Sections shall be renumbered appropriately, including all reference thereto.

18. The renumbered Section 2.9.4.5 shall be amended by adding new text and shall read as follows:

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.

19. The renumbered Section 2.9.4.6 shall be deleted and replaced in its entirety and shall read as follows:

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 has exceeded the ED threshold (see Section 2.14.1.10.2).

20. Section 2.11.8.1.4 shall be amended by adding the phrase "within the last six (6) months" so that the amended Section 2.11.8.1.4 shall read as follows:

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 seen and/or treated by the non-PCP provider within the last six (6) months. 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.

21. Section 2.11.8.2.3.1 shall be amended by adding new text and shall read as follows:

2.11.8.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit an excel spreadsheet that includes the provider's name, TennCare provider identification number, NPI number, and the number of enrollees affected within five (5) business days of the provider's termination. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR. The CONTRACTOR shall maintain documentation of all information, including a copy of the actual member notice(s) on-site. Upon request, the CONTRACTOR shall provide TENNCARE a copy of the following: one or more of the actual member notices mailed, an electronic listing in Excel identifying each member to whom a notice was sent,. a transition plan for the enrollees affected, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements.

22. Section 2.12.7 shall be amended by adding a new Section 2.12.7.53 and renumbering existing subparts accordingly, including any references thereto.

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 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 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;

23. Sections 2.13.5.1 and 2.13.5.2 shall be deleted in their entirety and replaced with the following:

2.13.5.1 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

2.13.5.2 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.

24. Section 2.15.3 shall be deleted in its entirety and replaced with the following:

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 improvement strategies for achieving the performance goal set for each PIP and promoting 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 shall be prior approved by TENNCARE.

25. Section 2.15.4 shall be deleted in its entirety and subsequent sections shall be renumbered accordingly, including any references thereto.

26. The renumbered Section 2.15.4 shall be deleted in its entirety and replaced with the following:

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.

27. The renumbered Section 2.15.6.1 shall be amended by adding new text and shall read as follows:

2.15.6.1 Annually, beginning with HEDIS 2010, 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 HEDIS measure results shall be reported separately for each Grand Region in which the CONTRACTOR operates. 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.

28. The renumbered Section 2.15.6.2 shall be amended by adding new text and shall read as follows:

2.15.6.2 Annually, beginning in 2010, 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. The CAHPS survey results shall be reported separately for each Grand Region in which the CONTRACTOR operates. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year.

29. Section 2.17.1.4 shall be deleted and replaced in its entirety as follows:

2.17.1.4 Once member materials have been approved in writing by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version (PDF) of the final printed product unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Should TENNCARE request original prints be submitted in hard copy, 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.

30. Section 2.17.4.5.4 shall be deleted in its entirety and replaced with the following:

2.17.4.5.4 Shall include a description of services provided including benefit limits, exclusions, and use of non-contract providers;

31. Section 2.18.7.3 shall be deleted in its entirety and replaced with the following:

2.18.7.3 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, provider education, 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.

32. Section 2.21.8 shall be deleted and replaced in its entirety so that the amended 2.21.8 shall read as follows:

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. 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. This disclosure shall be made in accordance with the requirements in Section 2.30.14.2. The following information shall be disclosed:

33. Section 2.22.2.1 shall be deleted in its entirety and replaced with the following:

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 and report service use against hard benefit limits in accordance with a methodology set by TENNCARE.

34. Section 2.22.6.1 shall be amended by replacing "quarterly" with "monthly":

2.22.6.1 On a monthly basis the CONTRACTOR shall submit claims payment accuracy percentage reports (see Section 2.30.15).

35. Section 2.22.6.3 shall be deleted in its entirety and replaced with the following:

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 56-32-226(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.

36. Section 2.24.1.3 shall be shall be amended by adding new text and shall read as follows:

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.

37. Section 2.30.1.4 shall be amended by adding new text and shall read as follows:

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.

38. Section 2.30.4.10 shall be deleted in it entirety and following subsections shall be renumbered accordingly, including any references thereto.

39. Section 2.30.5 is amended by adding a new Subsection 2.30.5.3 which shall read as follows:

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.

40. Section 2.30.6.1.1 shall be deleted in its entirety and replaced with the following:

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.

41. Section 2.30.6.1 shall be amended by adding a new Section 2.30.6.1.2 and renumbering existing subparts accordingly, including any references thereto.

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.

42. Section 2.30.9 shall be deleted and replaced in its entirety and shall read as follows:

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 monthly *Check Run Summaries* on at least a monthly basis. The summaries should be submitted for the relevant adjudication cycle(s) during the reporting period.

2.30.9.3 The CONTRACTOR shall submit a *Claims Data Extract* that shall be due at least on a monthly basis along with the *Check Run Summaries* and shall be submitted for the relevant adjudication cycle(s) during the reporting period.

2.30.9.4 The CONTRACTOR shall provide a *Reconciliation Report* 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 fourteen (14) days of the claims data extract.

43. Section 2.30.10.5 shall be deleted in its entirety and replaced with the following:

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.

44. Section 2.30.10.8 shall be deleted in its entirety and the existing following subparts shall be renumbered accordingly, including any references thereto.

45. Section 2.30.11.1 shall be amended by adding new text and shall read as follows:

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.

46. Section 2.30.11.1.1 shall be deleted in its entirety.

47. Section 2.30.11.2 shall be deleted in its entirety and the existing subparts shall be renumbered accordingly, including any references thereto.

48. The renumbered Section 2.30.11.2 shall be amended by adding new text and shall read as follows:

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.

49. Section 2.30.11 shall be amended by adding a new Section 2.30.11.5 which shall read as follows:

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.

50. Section 2.30.15.1 shall be deleted in its entirety and replaced with the following:

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.

51. Section 2.30.14.3.4 shall be amended to revise the due dates as follows:

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 15 (covering third quarter of current year). Each quarterly report shall also contain 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.

52. Section 2.30.19 shall be shall be amended by adding new text and shall read as follows:

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.

53. Section 2.31 is deleted in its entirety.

54. Section 3.10.2 through 3.10.4 shall be deleted and replaced in their entirety.

3.10.2 Physical Health HEDIS Measures

3.10.2.1 On July 1 of the year that the first HEDIS reports are due (see Section 2.15.6), 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 3.10.2.2 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 3.10.5 below).

3.10.2.2 Beginning on July 1, 2011, 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 3.10.2.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR's HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below)..

3.10.2.3 Incentive payments will be available for the following audited HEDIS measures:

3.10.2.3.1 HbA1C Testing – Diabetes measure;

3.10.2.3.2 HbA1C Control – Diabetes measure;

3.10.2.3.3 LDL-C Screening Performed – Diabetes measure;

3.10.2.3.4 Adolescent Well-Care Visits;

3.10.2.3.5 Breast Cancer Screening; and

3.10.2.3.6 Controlling High Blood Pressure.

3.10.2.4 For HbA1C control, the reverse of the HEDIS measure (i.e. 100 minus the percentage of individuals with poorly controlled HbA1C) will serve as the measure for purposes of this section.

3.10.3 Behavioral Health HEDIS Measures

3.10.3.1 On July 1 of the year that the first HEDIS reports are due (see Section 2.15.6) 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 (calculated from the preceding calendar year's data) for which the CONTRACTOR scores at or above the 75th national Medicaid percentile, as calculated by NCQA. To be eligible for incentive payment for a measure, the CONTRACTOR must score at or above the 75th percentile for both rates comprising the measure.

3.10.3.2 Beginning July 1, 2011, the PMPM payment will be applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR'S HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. To be eligible for incentive payment for a measure, the CONTRACTOR must demonstrate significant improvement for both rates comprising the measure. Significant improvement is defined using NCQA's minimum effect size change methodology.

3.10.3.3 Audited HEDIS Measures:

3.10.3.3.1 Antidepressant Medication Management; and

3.10.3.3.2 Follow-up Care for Children Prescribed ADHD Medication.

3.10.4 Community Tenure/Hospital Readmission for Mental Illness

3.10.4.1 On July 1, of the year following the first full calendar year of operation, the CONTRACTOR will be eligible for a .$03 PMPM payment, applied to member months from the preceding calendar year, if significant improvement has been demonstrated in the rate at which members hospitalized for mental illness remain in the community (i.e. are not readmitted to an inpatient hospital setting for treatment of mental illness) within thirty (30) days of discharge. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below). The baseline rate will be the percentage of enrollees in the region that were discharged following hospitalization for mental illness during the last full calendar year prior to the year the CONTRACTOR began operating under this Agreement, and that were not readmitted within thirty (30) days following discharge, as calculated by TennCare. The baseline rate will be compared to the percentage of the CONTRACTOR's members that were discharged following hospitalization for mental illness during the first full calendar year of operation under this Agreement, and that were not readmitted within thirty (30 days) following discharge. The latter calculation will use methodology identical to that used in the baseline calculation performed by TENNCARE.

3.10.4.2 Beginning on July 1, 2011, 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, if significant improvement has been demonstrated in the rate at which members hospitalized for mental illness remain in the community (i.e. are not readmitted to an inpatient hospital setting for treatment of mental illness) within thirty (30) days of discharge. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below). The baseline rate will be the percentage of the CONTRACTOR's enrollees that were discharged following hospitalization for mental illness during the reporting period prior to the current reporting period and that were not readmitted within thirty (30) days following discharge, as calculated by TennCare. The baseline rate will be compared to the percentage of the CONTRACTOR's members that were discharged following hospitalization for mental illness during the preceding calendar year of operation, and that were not readmitted within thirty (30 days) following discharge. The latter calculation will use methodology identical to that used in the baseline calculation performed by TENNCARE.

55. Section 4.7.2 shall be deleted in its entirety.

56. Section 4.30 shall be deleted in its entirety and replaced with the following:

4.30 VOLUNTARY BUYOUT PROGRAM

4.30.1 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.

4.30.2 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.

4.30.3 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.

4.30.4 With reference to either Section 4.30.2 or 4.30.3 above, the 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 shall 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.

57. Section 4 shall be amended by adding a new Section 4.37 and renumbering the existing Sections accordingly, including any references thereto.

4.37 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:

4.37.1 The Recovery Act, including but not limited to the following sections of that Act:

4.37.1.1 Section 1606 – Wage Rate Requirements.

4.37.1.2 Section 1512 – Reporting and Registration Requirements.

4.37.1.3 Sections 902, 1514, and 1515 – General Accounting Office/Inspector General Access.

4.37.1.4 Section 1553 – Whistleblower Protections.

4.37.1.5 Section 1605 – Buy American Requirements for Construction Material.

4.37.2 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/.

4.37.3 Federal Grant Award Documents.

4.37.4 Office of Tennessee Recovery Act Management Directives.

58. In Attachment I, Behavioral Health Specialized Service Descriptions, the paragraph under "Peer Support" shall be shall be amended by adding new text and shall read as follows:

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.

59. In Attachment I, Behavioral Health Specialized Service Descriptions, the paragraph under "Supported Housing" shall be shall be deleted and replaced in its entirety and shall read as follows:

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.

60. Attachment II, Cost Sharing Schedule, shall be amended by adding the phrase "Prior to January 1, 2010" in the header of the current chart and adding a new chart which shall read as follows:

Non-Pharmacy Copayment Schedule Effective January 1, 2010
(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, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $15.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $20.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this attachment.

61. Attachment V, Access & Availability for Behavioral Health Services, shall be deleted in its entirety and replaced with the following:

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 10 business days; if urgent, within 48 hours
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 10 business days; if urgent, within 48 hours
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	Travel distance does not exceed	Within 10

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Treatment Services (Substance Abuse)*	75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of members	business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business 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 10 business 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:

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

62. In Attachment VII, Performance Standards, Performance Measure 1 (Timely Claims Processing), the text under "DEFINITION" shall be deleted in its entirety and replaced with the following:

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

63. In Attachment VII, Performance Standards, Performance Measure 1 (Timely Claims Processing), the text under "MEASUREMENT FREQUENCY" shall be amended by replacing "Quarterly" with "Monthly."

64. In Attachment VII, Performance Standards, Performance Measure 2 (Claims Payment Accuracy), the text under "DEFINITION" shall be deleted in its entirety and replaced with the following:

Percentage of total claims paid accurately for each month

65. In Attachment VII, Performance Standards, Performance Measure 2 (Claims Payment Accuracy), the text under "MEASUREMENT FREQUENCY" shall be amended by replacing "Quarterly" with "Monthly."

66. In Attachment VII, Performance Standards, Performance Measure 2 (Claims Payment Accuracy), the text under "LIQUIDATED DAMAGE" shall be amended by replacing "quarter" with "month" to read as follows:

$5,000 for each full percentage point accuracy is below 97% for each month

67. Attachment VIII, Deliverable Requirements, shall be amended to delete item #37 regarding clinical practice guidelines and renumber existing items accordingly.

68. In Attachment VIII, Deliverable Requirements, item #42 shall be amended by adding new text and shall read as follows:

42. Copy of signed NCQA survey contract as required by Section 2.15.6.1

69. Attachment VIII, Deliverable Requirements, shall be amended by adding a new item #47 regarding and renumbering existing items accordingly.

47. NCQA revaluation of accreditation status based on HEDIS scores (see Section 2.30.11.4)

70. Attachment VIII, Deliverable Requirements, shall be amended to delete item #130 regarding Emergency Room Visit Report and renumber following items accordingly.

71. Attachment VIII, Deliverable Requirements, shall be amended to delete item #133 regarding Quality Update Report and renumber following items accordingly.

72. Attachment IX, Exhibit G, Report of Essential Hospital Services, shall be deleted in its entirety and replaced with the following:

ATTACHMENT IX, 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 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 twelfth 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, 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 IX, 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 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

73. Delete Attachment IX, Exhibit L, Prior Authorization Report and replace with "Left Blank Intentionally".

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 September 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.
Commissioner

DATE: _____

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____

Sonya Nelson
President and Chief Executive Officer

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____

M. D. Goetz, Jr.
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____

Justin P. Wilson
Comptroller

DATE: _____