CONTRACT #8
RFS # 318.66-056
FA # 08-24979

Finance & Administration
Bureau of TennCare

VENDOR:
UnitedHealthCare Plan of the River Valley, Inc.
(West TN Region)

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

October 21, 2010

RECEIVED
OCT 21 2010
FISCAL REVIEW

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

Attention: Ms. Leni Chick

RE: Bureau of TennCare Contract Amendments

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee the following contract amendments. These amendments to the Managed Care Organizations provide language changes including: (1) address Program Integrity clarifications; (2) update Quality Performance measures; (3) provide CHOICES requirement clarifications; (4) update risk adjustment language modifications, and (5) various general housekeeping clarifications including numbering. There is no term extension or additional funding associated with these amendments.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-24
AMERIGROUP Tennessee, Inc.	FA-07-16936-07
UnitedHealthCare Plan of River Valley, Inc.	FA-07-16937-07
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-04
Volunteer State Health Plan (West Region)	FA-08-24978-04
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-04
Volunteer State Health Plan (East Region)	FA-08-24983-04

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, Director of Contracts

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	507-6415
*Original Contract Number:	FA-08-24979-00	*Original RFS Number:	318.66-056-08
Edison Contract Number: (*if applicable*)	N/A	Edison RFS Number: (*if applicable*)	N/A
*Original Contract Begin Date:	May 19, 2008	*Current End Date:	June 30, 2012
Current Request Amendment Number: (*if applicable*)		4	
Proposed Amendment Effective Date: (*if applicable*)		January 1, 2011	
*Department Submitting:		Department of Finance and Administration	
*Division:		Bureau of TennCare	
*Date Submitted:		October 21, 2010	
*Submitted Within Sixty (60) days:		Yes	
If not, explain:		NA	
*Contract Vendor Name:		UnitedHealthCare Plan of the River Valley, Inc. (West Region)	
*Current Maximum Liability:		$1,486,132,800.00	

RECEIVED
OCT 21 2010
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*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: 2008	FY: 2009	FY: 2010	FY: 2011	FY	FY
$0.00	$327,533,200.00	$491,299,800.00	$667,299,800	$	$

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

FY: 2008	FY: 2009	FY: 2010	FY: 2011	FY	FY
$0.00	$267,572,091.06	$ 452,411,635.90	$223,418,104.59	$	$

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 prior to delivery of services 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.
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	N/A

Supplemental Documentation Required for Fiscal Review Committee

*Contract Funding Source/Amount:	State:	$436,920,932.00	Federal:	$1,049,211,868.00
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 - September 1, 2009	This amendment provided compliance with Mental Health Parity Act, provided clarification language to the contract, streamlined reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #2 – March 1, 2010	This amendment provided compliance with Long Term Care Community Choices Act of 2008 for the provision of home and community based services and restructuring the long-term care system in Tennessee.
Amendment #3 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.

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.

UnitedHealthCare Plan (Americhoice) - West

FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158200	0000021799	34,845,516.94	7/2/2010
31865	00158203	0000021799	2,477,136.96	7/2/2010
31865	00173115	0000021799	53,670,135.96	8/6/2010
31865	00173118	0000021799	2,487,105.60	8/6/2010
31865	00186273	0000021799	54,277,770.27	9/3/2010
31865	00186276	0000021799	2,654,464.76	9/3/2010
			150,412,130.49	
31865	00199536	0000021799	69,164,186.38	10/1/2010
31865	00199539	0000021799	3,841,787.72	10/1/2010
			73,005,974.10	

FY 2011 TOTAL **$223,418,104.59**

UnitedHealthCare Plan (Americhoice) - West

FY 2010

Pre-Edison Payments:

Vendor Invoice	Invoice Date	Voucher	TCS	18A	Total
			BHO PAYMENTS	MCO PAYMENTS	
RA100650629	6/29/2009	100650629		33,377,136.05	**33,377,136.05**
RA100650632	6/29/2009	100650632	2,679,295.95		**2,679,295.95**
RA100686182	8/4/2009	100686182		33,141,928.70	**33,141,928.70**
RA100686185	8/4/2009	100686185	2,959,786.13		**2,959,786.13**
RA100714796	9/1/2009	100714796	2,705,047.53		**2,705,047.53**
RA100714793	9/1/2009	100714793		32,292,884.47	**32,292,884.47**
			8,344,129.61	98,811,949.22	**107,156,078.83**

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006783	0000021799	35,689,864.26	10/5/2009
31865	00006786	0000021799	2,765,854.13	10/5/2009
31865	00015654	0000021799	32,766,310.96	11/6/2009
31865	00015657	0000021799	2,762,098.49	11/6/2009
31865	00022039	0000021799	33,427,291.62	12/7/2009
31865	00022042	0000021799	2,685,389.41	12/7/2009
31865	00018419	0000021799	1,248,854.37	11/19/2009
31865	00016960	0000021799	360,797.32	11/16/2009
31865	00016959	0000021799	181,054.69	11/16/2009
			111,887,515.25	
31865	00051201	0000021799	33,367,948.02	1/8/2010
31865	00051204	0000021799	2,841,012.86	1/8/2010
31865	00068251	0000021799	43,710,143.57	2/5/2010
31865	00068254	0000021799	2,178,842.45	2/5/2010
31865	00086762	0000021799	34,557,253.26	3/5/2010
31865	00086765	0000021799	2,658,621.88	3/5/2010
			119,313,822.04	

UnitedHealthCare Plan (AmeriChoice) - West FY 2010 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104916	0000021799	35,137,803.71	4/2/2010
31865	00104919	0000021799	2,828,514.72	4/2/2010
31865	00125594	0000021799	35,825,443.72	5/7/2010
31865	00125597	0000021799	2,531,057.14	5/7/2010
31865	00142688	0000021799	35,048,111.49	6/4/2010
31865	00142691	0000021799	2,683,289.00	6/4/2010
			114,054,219.78	

FY 2010 TOTAL **$452,411,635.90**

MCO 030 AMERICHOICE WEST

PAYMENT DATE	NET PAYMENT	NET PAYMENT	**Total Capitation**
4-Nov-08	29,960,012.13	2,082,051.39	**32,042,063.52**
5-Dec-08	27,732,784.26	2,169,443.38	**29,902,227.64**
1-Jan-09	30,456,502.53	2,573,150.89	**33,029,653.42**
3-Feb-09	31,312,367.94	2,407,160.81	**33,719,528.75**
6-Mar-09	31,261,339.12	2,295,182.31	**33,556,521.43**
1-Apr-09	31,270,404.87	2,787,721.77	**34,058,126.64**
28-Apr-09	31,698,603.12	2,681,946.71	**34,380,549.83**
2-Jun-09	34,013,725.57	2,869,694.26	**36,883,419.83**
Total 2009	**247,705,739.54**	**19,866,351.52**	**267,572,091.06**

ATTACHMENT XII

CAPITATION RATES
WEST GRAND REGION
EFFECTIVE November 1, 2008 through June 30, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	**Age Under 1**	**$ 469.10**
	Age 1 - 13	**$ 97.24**
	Age 14 - 20 Female	**$ 185.88**
	Age 14 - 20 Male	**$ 84.25**
	Age 21 - 44 Female	**$ 275.89**
	Age 21 - 44 Male	**$ 132.34**
	Age 45 – 64	**$ 349.07**
	Age 65 +	**$ 307.07**
Uninsured/Uninsurable	**Age Under 1**	**$ 469.10**
	Age 1 - 13	**$ 71.11**
	Age 14 - 19 Female	**$ 96.45**
	Age 14 – 19 Male	**$ 78.47**
Disabled	**Age < 21**	**$ 780.67**
	Age 21 +	**$ 635.60**
Duals/Waiver Duals	**All Ages**	**$ 69.56**
State Only & Judicials	**All Ages**	**$ 558.22**
Priority Add-On	**All Ages**	**$ 243.05**

50. **Attachment XII shall be amended by labeling the existing Rate Chart as EXHIBIT A, deleting and replacing the existing reference to "June 30, 2010" with "June 30, 2009" and adding a new EXHIBIT B as follows:**

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

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related)	**Age Under 1**	**$ 486.47**
And	**Age 1 - 13**	**$ 100.84**
Standard Spend Down	**Age 14 - 20 Female**	**$ 192.83**
	Age 14 - 20 Male	**$ 87.37**
	Age 21 - 44 Female	**$ 285.14**
	Age 21 - 44 Male	**$ 127.57**
	Age 45 – 64	**$ 334.96**
	Age 65 +	**$ 352.40**
Uninsured/Uninsurable	**Age Under 1**	**$ 486.47**
	Age 1 - 13	**$ 73.74**
	Age 14 - 19 Female	**$ 100.02**
	Age 14 – 19 Male	**$ 81.38**
Disabled	**Age < 21**	**$ 862.74**
	Age 21 +	**$ 739.61**
Duals/Waiver Duals	**All Ages**	**$ 77.17**
Priority Add-On	**All Ages**	**$ 248.12**
CHOICES Rate (Effective upon the CHOICES Implementation Date)	**CHOICES Duals**	**To Be Provided**
	CHOICES Non-Duals	**To Be Provided**

51. **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).**

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)

29. EXHIBIT B of Attachment XII shall be amended by inserting the CHOICES Rates as follows:

CHOICES Rate (Effective upon the CHOICES Implementation Date)	**CHOICES Duals**	**$ 4,228.59**
	CHOICES Non-Duals	**$ 5,638.49**

NON-AMD123008

NON-COMPETITIVE AMENDMENT REQUEST:

APPROVED
Commissioner of Finance & Administration

1) RFS #	318.66-056-08
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 West Tennessee Region
4) Contractor :	UnitedHealthCare Plan of the River Valley, Inc. (AmeriChoice)
5) Contract #	FA-08-24979-00
6) Contract Start Date :	May 19, 2008
7) CURRENT Contract End Date : (if ALL options to extend the contract are exercised)	June 30, 2012
8) CURRENT Maximum Cost : (if ALL options to extend the contract are exercised)	$ 1,486,132,800.00
PROPOSED AMENDMENT INFORMATON	
9) Amendment #	4
10) Amendment Effective Date : (attached explanation required if < 60 days after F&A receipt)	January 1, 2011
11) PROPOSED Contract End Date : (if ALL options to extend the contract are exercised)	June 30, 2012
12) PROPOSED Maximum Cost : (if ALL options to extend the contract are exercised)	$ 1,486,132,800.00

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) Address Program Integrity clarifications; (2) Update Quality Performance measures, (3) Provide CHOICES requirement clarifications; (4) Update risk adjustment language modifications, and (5) various general housekeeping clarifications including numbering and typos. There is no term extension or additional funding associated with this amendment.

15) Explanation of Need for the Proposed Amendment :

This contract is a competitively procured contract providing medical and behavioral services to TennCare enrollees. This amendment is needed to provide required language clarifications relating to enforcement of the CHOICES program, program integrity clarifications and risk adjustment language modifications. There is no term extension or additional funding associated with this amendment.

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

Richard L. Bartsh, M.D.
President
United Healthcare Plan of River Valley, Inc.

1300 River Drive
Moline, IL 61265

NON-AMD123008

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 West Tennessee Region. This amendment adds language changes and clarifications to existing competitively procured contract.

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, clarifications and modifications associated with program integrity, performance measures and risk adjustment. The Bureau of TennCare feels this amendment represents necessary changes to comply with State law and that also 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 MD Goetz 10/8/10

CONTRACT NOT PAID THROUGH EDISON
CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
318.66-056	FA-08-24979-04
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare of the River Valley, Inc.	☐ C- or ☒ V-

Service Description

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

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
May 19, 2008	June 30, 2012	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	$117,459,956.00	$210,073,244.00			$327,533,200.00
2010	$122,407,345.00	$368,892,455.00			$491,299,800.00
2011	$197,053,631.00	$470,246,169.00			$667,299,800.00
TOTAL:	$436,920,932.00	$1,049,211,868.00			**$1,486,132,800.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2008	0.00	0.00
2009	$327,533,200.00	0.00
2010	$491,299,800.00	0.00
2011	$667,299,800.00	0.00
TOTAL:	**$1,486,132,800.00**	**0.00**
End Date:	**6/30/2012**	**6/30/2012**

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 4
WEST
CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA- 08-24979-00

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. Section 1 shall be amended by deleting and replacing the following definitions:

Base Capitation Rate: The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement as compensation for the provision of all covered services.

Capitation Payment: The fee that is paid by TENNCARE to the CONTRACTOR for each member covered by this Agreement. The CONTRACTOR is at financial risk as specified in Section 3 of this Agreement for the payment of services incurred in excess of the amount of the capitation payment. "Capitation Payment" includes Base Capitation Rate payments unless otherwise specified.

Capitation Rate: The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement, including the base capitation rates.

Priority Enrollee: An enrollee that has been identified by TENNCARE as vulnerable due to certain mental health diagnoses.

2. Section 1 shall be amended by deleting the following definitions: "Clinically Related Group 1: Severely and/or Persistently Mentally Ill (SPMI)", "Clinically Related Group 2: Persons with Severe Mental Illness (SMI)", "Clinically Related Group 3: Persons who are Formerly Severely Impaired", "Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders", "Clinically Related Group 5: Persons who are not in clinically related groups 1-4 as a result of their diagnosis", "CRG (Clinically Related Group)", "Priority Add on Rate", "Seriously Emotionally Disturbed (SED)", "Severely and/or Persistently Mentally Ill (SPMI)" and "Target Population Group (TPG)".

3. Section 2.7.1.2 and 2.7.1.3 shall be amended by adding a new sentence to the end of the existing language as follows:

2.7.1.2 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency medical condition specified in Section 1 of this Agreement. The CONTRACTOR shall base coverage decisions for emergency services on

the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. The CONTRACTOR shall have policies that address emergency and non-emergency use of services provided in an outpatient emergency setting.

2.7.1.3 The CONTRACTOR shall provide coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contract provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services shall be provided without prior authorization in accordance with 42 CFR 438.114. The CONTRACTOR shall pay for any emergency screening examination services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized. However, the CONTRACTOR shall have policies to determine when non- emergency services are provided in an outpatient emergency setting.

4. Section 2.7.2.8.1.5 shall be deleted and replaced as follows:

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a crisis team consultation is completed for all members evaluated by a licensed physician or psychologist as described in TennCare policy. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

5. Sections 2.7.2.9 through 2.7.2.9.7 shall be deleted in their entirety and the remaining Section 2.7.2 shall be renumbered accordingly including any references thereto.

6. Section 2.7.6.2.10.1 and 2.7.6.2.10.1.1 shall be deleted and replaced as follows:

2.7.6.2.10.1 The minimum number of outreach events shall equal no less than twenty-five (25) per quarter for each region, with a total of at least one hundred and fifty (150) per year, per region.

2.7.6.2.10.1.1 A minimum of forty five (45) of the one hundred and fifty (150) events shall be targeted at counties designated as rural/suburban. The MCOs shall conduct outreach events throughout the region they serve to ensure all members have reasonable access to events during a calendar year. Results of the CONTRACTOR's or State's CMS 416 and HEDIS reports, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific populations, particularly members who have limited English proficiency, low literacy levels, behavioral health needs, special health care needs or who are pregnant.

7. Section 2.7.8.1 shall be deleted and replaced as follows:

2.7.8.1 The CONTRACTOR shall cover abortions, sterilizations, and hysterectomies (ASH) pursuant to applicable federal and state law. The CONTRACTOR shall ensure that when coverage requires the completion of a specific form, the form is properly completed as described in the

instructions with the original form maintained in the member's medical records and a copy submitted to the CONTRACTOR for retention in the event of audit. In the event of a TennCare audit the CONTRACTOR will provide additional supporting documentation to ascertain compliance with federal and state regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders, or other documentation utilized to authorize ASH procedures utilized to authorize ASH procedures, specific to the type of procedure performed.

8. Section 2.8.1 shall be amended by deleting and replacing Section 2.8.1.2, adding a new Section 2.8.1.3 and renumbering the existing Sections accordingly including any references thereto.

2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee as a clinical basis for development of program content and plan of care.

2.8.1.3 For the conditions listed in Sections 2.8.1.1.1 through 2.8.1.1.7, the DM Health Risk Assessment shall include screening for mental health and substance abuse. For conditions listed in Sections 2.8.1.1.8 through 2.8.1.1.10, the DM Health Risk Assessment shall include an evaluation for co-occurring disorders.

9. Section 2.8.3 shall be amended by renumbering the existing text as 2.8.3.1 and adding new text in a new Section 2.8.3.2 as follows:

2.8.3 **Stratification**

2.8.3.1 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 which, for members enrolled in the CHOICES program shall also include stratification by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The DM programs shall tailor the program content and education activities for each stratification level. For CHOICES members, this shall include targeted interventions based on the setting in which the member resides.

2.8.3.2 As a part of the Maternity DM program, the contractor shall classify all pregnant women who use tobacco in the high risk category and refer those members, who consent, to the Tennessee Tobacco Quitline using the Quitline referral form (or a TENNCARE approved smoking cessation program).

10. Section 2.8.4 shall be deleted and replaced as follows:

2.8.4 **Program Content**

Each DM program shall include the development of program content plans, as described in NCQA Disease Management Standards as treatment plans, to serve as the outline for all of the activities and interventions in the program focusing on patient empowerment strategies to support the provider-patient relationship. At a minimum the activities and interventions shall address condition monitoring, patient adherence to the program, consideration of other co-morbidities, and condition-related lifestyle issues. For CHOICES members, appropriate elements of the program content plan shall be individualized and integrated into the member's plan of care to facilitate better management of the member's condition.

11. Section 2.8.7.2 through 2.8.7.2.6 shall be deleted and replaced with new Sections 2.8.7.2, and 2.8.7.3 through 2.8.7.3.6 as described below. The current Section 2.8.7.3 shall be renumbered as 2.8.7.4.

2.8.7.2 The CONRACTOR shall report the passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs.

2.8.7.3 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. The calculations for the benchmarks and goals should include non-CHOICES members only. These benchmarks and goals shall include:

2.8.7.3.1 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.3.2 Neonatal Intensive Care Unit (NICU) data associated with members enrolled in the maternity care management program;

2.8.7.3.3 Appropriate HEDIS measures;

2.8.7.3.4 Member adherence to treatment plans;

2.8.7.3.5 Provider adherence to the guidelines; and

2.8.7.3.6 DM specific member satisfaction survey results.

12. Sections 2.9.4.2.7.1 and 2.9.4.2.7.2 shall be deleted and replaced as follows and the remaining Section 2.9.4.2.7 shall be renumbered accordingly including any references thereto.

2.9.4.2.7.1 Priority Enrollees;

13. Section 2.9.5.1.5 shall be deleted and replaced as follows:

2.9.5.1.5 Program Evaluation (Satisfaction and Effectiveness) which shall include the following:

2.9.5.1.5.1 The rate of in-patient admissions and re-admissions of CM members;

2.9.5.1.5.2 The rate of ED utilization by CM members; and

2.9.5.1.5.3 Percent of member satisfaction specific to CM.

14. Section 2.9.6.2.4 shall be amended by deleting and replacing Section 2.9.6.2.4.2, deleting Sections 2.9.6.2.4.3 and 2.9.6.2.4.4 and renumbering the remaining Section 2.9.6.2.4 as appropriate including all references thereto.

2.9.6.2.4.2 For members in CHOICES Group 1 who are receiving services in a nursing facility at the time of enrollment in, the CONTRACTOR shall immediately authorize NF services in accordance with the level of nursing facility services or reimbursement approved by

TENNCARE, and as of the effective date of CHOICES enrollment. The CONTRACTOR shall, within thirty (30) calendar days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member and perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1). The care coordinator shall review the plan of care developed by the nursing facility and may supplement the plan of care as necessary and appropriate (see Section 2.9.6.6.1).

15. Section 2.9.6.2.5.2 and 2.9.6.2.5.3 shall be deleted and replaced as follows:

2.9.6.2.5.2 For members in CHOICES Group 2 who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within ten (10) business days of notice of the member's enrollment in CHOICES the care coordinator shall conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate additional HCBS specified in the plan of care (i.e., assistive technology), except in the case of members enrolled on the basis of Immediate Eligibility. If a member residing in a community-based residential alternative setting is enrolled on the basis of Immediate Eligibility, the CONTRACTOR shall, upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, immediately authorize community-based residential services and shall authorize and initiate additional HCBS specified in the member's plan of care (i.e., assistive technology) within five (5) days of notice; authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.9.6.2.5.3 The care coordinator shall, for all other CHOICES members in Groups 2 and 3 not specified in 2.9.6.2.5.1 – 2.9.6.2.5.2 above, within ten (10) business days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate HCBS, except in the case of members enrolled on the basis of Immediate Eligibility in which case only the limited package of HCBS shall be authorized and initiated. Members enrolled on the basis of Immediate Eligibility shall have access only to a limited package of HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES; however all needed services shall be listed in the plan of care, and the CONTRACTOR shall immediately revise the service authorizations as necessary upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES and initiate services within ten (10) business days of notice.

16. The first paragraph numbered Section 2.9.6.3.17 shall be deleted and replaced as follows:

2.9.6.3.17 For all newly enrolled CHOICES Group 1 members, the CONTRACTOR shall immediately authorize NF services in accordance with the level of nursing facility services or reimbursement approved by TENNCARE, and as of the effective date of CHOICES enrollment. To the extent that applicable activities specified in Sections 2.9.6.3.8, 2.9.6.3.8.1 and 2.9.6.3.9 were not completed by the CONTRACTOR during the member's CHOICES enrollment process, the member's Care Coordinator shall within thirty (30) calendar days of notice of the member's enrollment in CHOICES Group 1, conduct a face-to-face visit, perform any additional needs assessment deemed necessary, and may supplement the plan of

care as necessary and appropriate.

For the CONTRACTOR's current members enrolled into CHOICES Group 2, the member's Care Coordinator shall within ten (10) business days of notice of the member's enrollment in CHOICES Group 2, authorize and initiate HCBS. To the extent that applicable activities specified in Sections 2.9.6.3.8, 2.9.6.3.8.2 and 2.9.6.3.9 were not completed by the CONTRACTOR during the member's CHOICES enrollment process, the member's Care Coordinator shall also within ten (10) business days of notice of the member's enrollment in CHOICES Group 2, conduct a face-to-face visit, perform a comprehensive needs assessment, and develop a plan of care.

17. Section 2.9.8.4 shall be deleted and replaced as follows:

2.9.8.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly priority enrollees are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health and long-term care providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information, as well as notification to the member's care coordinator.

18. Section 2.11.7.2 shall be deleted and replaced as follows:

2.11.7.2 Community Mental Health Agencies (CMHAs)

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

19. Section 2.12.9.60 shall be deleted and replaced as follows:

2.12.9.60 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements, including timeframes, specified in 42 CFR Part 455, Subpart B and at anytime upon request;

20. Section 2.12.15 shall be deleted in its entirety and the remaining Sections in 2.12 shall be renumbered accordingly including any references thereto.

21. The renumbered Section 2.12.15 shall be deleted and replaced as follows:

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

2.12.15.1 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, or physician's primary license if the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than 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.

2.12.15.2 The CONTRACTOR shall notice providers regarding across the board rate reductions and shall include language in the notice that describes those providers to be excluded from the across the board rate reduction in accordance with the Annual Coverage Assessment Act. The provider exclusion language shall be conspicuously placed on the front page of the notice and will advise providers who believe they meet the exclusion criteria specified in the Act of the process for demonstrating such to the MCO.

2.12.15.3 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 with the CONTRACTOR.

22. Section 2.15.7.6 shall be amended by deleting the word "monthly" and replacing it with the word "quarterly".

2.15.7.6 As specified in Section 2.30.11.6, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding all critical incidents.

23. Sections 2.18.7.4 and 2.18.7.5 shall be deleted and replaced as follows:

2.18.7.4 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, care coordination, and utilization management processes, including medical reviews. The CONTRACTOR shall include questions specified by TENNCARE. 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 and provide an update on actions taken in the previous year to improve provider satisfaction. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

2.18.7.5 The CONTRACTOR shall conduct an annual satisfaction survey of CHOICES long-term care providers that shall include any questions specified in the survey tool provided by TENNCARE. 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 and provide an update on actions taken in the previous year to improve provider satisfaction. .

24. Section 2.20 shall be deleted and replaced as follows:

2.20 FRAUD AND ABUSE

2.20.1 **General**

2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.

2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.

2.20.1.3 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

2.20.1.4 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

2.20.1.5 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

2.20.2 **Reporting and Investigating Suspected Fraud and Abuse**

2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement. The CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.1.1 Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG;

2.20.2.2 The CONTRACTOR shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU and TennCare Office of Program Integrity; and

2.20.2.2.1 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG;

2.20.2.3 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment VI, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Agreement.

2.20.2.4 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.

2.20.2.5 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:

2.20.2.5.1 Contact the subject of the investigation about any matters related to the investigation;

2.20.2.5.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

2.20.2.5.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

2.20.2.6 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

2.20.2.7 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

2.20.2.8 The State shall not transfer its law enforcement functions to the CONTRACTOR.

2.20.2.9 The CONTRACTOR and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.

2.20.2.10 The CONTRACTOR shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.

2.20.2.11 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.

2.20.2.12 Except as described in Section 2.11.7.2 of this Agreement, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.

2.20.3 **Compliance Plan**

2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Agreement execution and annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request.

2.20.3.2 The CONTRACTOR's fraud and abuse compliance plan shall:

2.20.3.2.1 Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Agreement;

2.20.3.2.2 Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;

2.20.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste and on identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;

2.20.3.2.4 Outline unique policy and procedures, and specific instruments designed to identify, investigate, and report fraud and abuse activities under the CHOICES' program.

2.20.3.2.5 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Agreement; and

2.20.3.2.6 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:

2.20.3.2.6.1 A list of automated pre-payment claims edits;

2.20.3.2.6.2 A list of automated post-payment claims edits;

2.20.3.2.6.3 A list of desk audits on post-processing review of claims;

2.20.3.2.6.4 A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

2.20.3.2.6.5 A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

2.20.3.2.6.6 A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials; and

2.20.3.2.6.7 A list of references in provider and member material regarding fraud and abuse referrals.

2.20.3.2.7 A list of provisions for the confidential reporting of plan violations to the designated person;

2.20.3.2.8 A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;

2.20.3.2.9 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;

2.20.3.2.10 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

2.20.3.2.11 Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU as well as TennCare Office of Program Integrity and that enrollee fraud and abuse be reported to the OIG; and

2.20.3.2.12 Ensure that no individual who reports MCO violations or suspected fraud and abuse is retaliated against.

2.20.3.3 The CONTRACTOR shall have provisions regarding compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.

2.20.3.4 The CONTRACTOR shall provide a list of procedures regarding implementation of TennCare policy on disclosure and adverse action reporting (http://www.tn.gov/tenncare/forms/fa10-001.pdf).

2.20.3.5 The CONTRACTOR shall have provisions in its Compliance plan regarding the reporting of fraud and abuse activities as required in Section 2.30.13, Reporting Requirements.

2.20.3.6 The CONTRACTOR shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against either the Medicare Exclusion Database (the MED) or the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The CONTRACTOR must establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.

2.20.3.7 The CONTRACTOR shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The CONTRACTOR shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The CONTRACTOR shall provide the State Agency with such database and a monthly report of the exclusion check.

2.20.3.8 The CONTRACTOR shall have provisions in its Compliance Plan regarding prompt terminations of inactive providers due to inactivity in the past 12 months.

25. Section 2.21.4.1.3 through 2.21.4.1.3.3 shall be deleted and replaced as follows:

2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for services described in TennCare policy, including the State Medicaid Manual, Section 3904.4.

26. The opening paragraph in Section 2.21.9 through Section 2.21.9.5.5 shall be deleted and replaced as follows:

2.21.9 **Ownership and Financial Disclosure**

2.21.9.1 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 the time and manner set forth in accordance with federal and state requirements, including 42 CFR §55.104 and Public Chapter 379 of the Acts of 1999.

2.21.9.2 The CONTRACTOR and its subcontractors shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. 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 results of said screenings shall be provided to TENNCARE on a monthly basis. 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, owners, agents, managing employees, etc.

2.21.9.3 The CONTRACTOR and its subcontractors shall agree to disclose business transaction information <u>upon request and as otherwise</u> specified in federal and state regulations.

2.21.9.4 Disclosures shall be made in accordance with the requirements in Section 2.30.15.2.2. The following information shall be disclosed:

2.21.9.4.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider, subcontractor or fiscal agent in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

2.21.9.4.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the disclosure,

and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;

2.21.9.4.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;

2.21.9.4.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;

2.21.9.4.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:

2.21.9.4.5.1 The CONTRACTOR shall disclose the following transactions:

2.21.9.4.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;

2.21.9.4.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and

2.21.9.4.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

2.21.9.4.5.2 The information which shall be disclosed in the transactions includes:

2.21.9.4.5.2.1 The name of the party in interest for each transaction;

2.21.9.4.5.2.2 A description of each transaction and the quantity or units involved;

2.21.9.4.5.2.3 The accrued dollar value of each transaction during the fiscal year; and

2.21.9.4.5.2.4 Justification of the reasonableness of each transaction.

2.21.9.4.5.3 If the Agreement is being renewed or extended, the CONTRACTOR shall disclose information on business transactions which occurred during the prior contract period. If the Agreement is an initial Agreement with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions shall be reported.

2.21.9.4.5.4 A party in interest is:

2.21.9.4.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial

owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

2.21.9.4.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

2.21.9.4.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or

2.21.9.4.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.9.5.4.1, 2.21.9.5.4.2, or 2.21.9.5.4.3

2.21.9.4.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

27. Section 2.24.2.1 shall be deleted and replaced as follows:

2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include individuals and/or families of those who may meet the clinical criteria of a priority enrollee.

28. Sections 2.28.2 and 2.28.7 shall be deleted and replaced as follows:

2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall develop a CONTRACTOR non-discrimination compliance training plan. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding the CONTRACTOR's non-discrimination policies and procedures and all applicable non-discrimination compliance requirements of the plan.. The CONTRACTOR shall be able to show documented proof of such instruction.

2.28.7 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees, enrollees, providers and subcontractors related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the TennCare program), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare MCO. The CONTRACTOR shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; CONTRACTOR's resolution, date of resolution; and name of CONTRACTOR staff person responsible for adjudication of the complaint.

29. Section 2.30.4.2 shall be deleted and replaced as follows:

2.30.4.2 The CONTRACTOR shall submit a quarterly *Post-Discharge Services Report* that provides information on Post-Discharge services appointments. The minimum data elements required are identified in Attachment IX, Exhibit B.

30. Section 2.30.4.3 and Sections 2.30.4.5 through 2.30.4.8 shall be deleted in their entirety and the remaining Sections of 2.30.4 shall be renumbered accordingly including any references thereto.

31. Sections 2.30.5.1 and 2.30.5.2 shall be deleted and replaced as follows:

2.30.5.1 The CONTRACTOR shall submit a quarterly Disease Management Update Report that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall include the number of pregnant women identified as tobacco users who were actively referred to the Tennessee Tobacco Quitline and their referral status and other interventions around smoking cessation performed during the quarter. The report shall include a chart and narrative for CHOICES members in DM to include the total number of members receiving DM interventions, by DM condition; the total number of CHOICES members starting and terminating DM interventions during the quarter, a description of any specific provider and member interventions that were new during the quarter, the number of member and provider activities/interventions, and a written analysis of data provided.

2.30.5.2 The CONTRACTOR shall submit on July 1 an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the eligibility criteria and the method used to identify and enroll eligible members, the passive participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, a description of stratification levels for each DM program including member criteria and associated interventions, a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation, a summary of member satisfaction with the DM program, a written analysis of the data presented, a description of proposed changes to program, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7 including the number of pregnant women identified as tobacco users who were actively referred to the

Tennessee Tobacco Quitline and their referral status. The report shall include a separate chart(s) and narrative for CHOICES members in DM to include a narrative description of the eligibility criteria and the method used to identify and enroll eligible CHOICES members, a description of stratification levels based on the setting in which the member resides; total number of CHOICES members identified as having a DM condition, total number of members receiving DM activities/interventions, and the number of CHOICES members by level of stratification; a discussion of barriers and challenges to include resources, program structure, member involvement, and provider participation along with a description of proposed changes.

32. Section 2.30.7.8 shall be deleted in its entirety.

33. Section 2.30.12.4 shall be deleted and replaced as follows:

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that encompasses behavioral and physical health as well as a *CHOICES Provider Satisfaction Survey Report* that addresses results for CHOICES long-term care providers. The report shall summarize the provider survey methods and findings for each of the three groups and must provide an analysis of opportunities for improvement (see Section 2.18.7.4 and 2.18.7.5) in addition to CHOICES items specified in the protocols provided by TENNCARE. The reports shall be submitted by July 1 each year.

34. Sections 2.30.14.1, 2.30.14.5 and 2.30.14.6 shall be deleted and replaced as follows:

2.30.14.1 The CONTRACTOR shall submit a quarterly 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. The report shall be submitted in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).

2.30.14.5 The CONTRACTOR shall submit a monthly 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) (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp), the CMS MED (Medicare Exclusion Database), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

2.30.14.6 The CONTRACTOR shall submit a monthly List of Involuntary Terminations Report (including providers termed due to sanctions, invalid licenses, services and billing concerns, etc.) due to program integrity concerns to TENNCARE.

35. Section 2.30.15.2.2 shall be deleted and replaced as follows:

2.30.15.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* (http://www.tn.gov/tenncare/forms/disclosureownership.pdf) to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.9 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

36. Section 2.30.21.2 shall be deleted and replaced as follows:

2.30.21.2 The CONTRACTOR shall submit an annual *Summary Listing of Servicing Providers*. The listing shall include, at a minimum, provider name, address, race or ethnic origin, language spoken other than English and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The CONTRACTOR shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by TENNCARE.

37. Section 2.30.21.4.2 shall be deleted and replaced as follows:

2.30.21.4.2 A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, date of resolution, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint; and

38. Section 3.3.3 shall be deleted in its entirety and the remaining Section 3.3 shall be renumbered accordingly including any references thereto.

39. Sections 3.4.3.3 and 3.4.3.4 shall be deleted and replaced as follows:

3.4.3.3 Health plan risk assessment scores will be recalibrated annually based upon health status information derived from encounter data submitted to TENNCARE by MCOs serving the Grand Region through the most recent twelve (12) month period deemed appropriate by the State's actuary. If the health plan risk assessment score for any MCO deviates from the profile for the Grand Region being served by the MCO by more than three percent (3%), whether a negative or positive change in scores, the base capitation rates as subsequently adjusted will be proportionally adjusted.

3.4.3.3.1 The risk assessment covering July 1, 2010 through June 30, 2011 shall be derived from encounter data submitted to TENNCARE by MCO's serving the grand region through the most recent twelve (12) month period deemed appropriate by the state's actuary. The assessment shall be completed during fiscal year 2011. If the health plan risk assessment score for any MCO deviates from the profile for the Grand region being served by the MCO by more than 2%, whether a negative or a positive change in scores, the base capitation rates will be proportionally adjusted for the period covering July 1, 2010 through June 30, 2011.

3.4.3.3.2 The risk assessment covering July 1, 2011 through June 30, 2012 shall be derived from encounter data submitted to TENNCARE by MCO's serving the grand region through the most recent twelve (12) month period deemed appropriate by the state's actuary. The assessment shall be completed during fiscal year 2012. If the health plan risk assessment score for any MCO deviates from the profile for the Grand region being served by the MCO by more than 1%, whether a negative or a positive change in scores, the base capitation rates will be proportionally adjusted for the period covering July 1, 2011 through June 30, 2012.

3.4.3.4 TENNCARE will recalibrate health plan risk assessment scores on an ongoing basis for the purpose of monitoring shifts in enrollment. If warranted prior to the next scheduled annual

recalibration as demonstrated by a significant change in health plan risk assessment scores, TENNCARE may adjust the original base capitation rates as subsequently adjusted for all MCOs.

40. Section 3.4.4 shall be amended by adding new text to the end as follows:

3.4.4 Beginning with capitation payment rates effective July 1, 2008, in addition to other adjustments specified in Section 3.4 of this Agreement, the base capitation rates as subsequently adjusted and the priority add-on rates shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary. The priority add-on rate will terminate on 12/31/2010.

41. Section 3.13.3 shall be amended by adding new text to the end as follows:

3.13.3 **Capitation Payment Amounts After the First Year**

The base capitation rates (see Section 3) for the period from the start date of operations to June 30, 2010 for all rate categories will be established through a competitive bid process, and the priority add-on rate will be established by the State. The base capitation rates, priority add-on rate for subsequent years will be set by Notice as provided under Section 3.4.2 of this Agreement. The priority add-on rate will terminate on 12/31/2010.

42. Section 4.3 shall be amended by adding a new Section 4.3.46 as follows:

4.3.46 Patient Protection and Affordable Care Act (PPACA).

43. Item A.9 of Section 4.20.2.2.7 shall be deleted and replaced as follows:

A.9	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by TENNCARE rules or regulations, applicable state or federal law, and all court orders and consent decrees governing appeal procedures as they become effective		An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense $500 per day for each calendar day the CONTRACTOR fails to provide continuation or restoration of services as required by TENNCARE or approved by the CONTRACTOR

44. Items B.21 and B.22 of Section 4.20.2.2.7 shall be deleted in their entirety.

45. The paragraph regarding "Supported Housing" in Attachment I shall be deleted and replaced as follows:

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for priority enrollees 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.

46. Attachment III shall be deleted and replaced as follows:

ATTACHMENT III

GENERAL ACCESS STANDARDS

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:

  (a) Distance/Time Rural: 30 miles or 30 minutes

  (b) Distance/Time Urban: 20 miles or 30 minutes

  (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.

  (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

  (e) Documentation/Tracking requirements:

    + Documentation - Plans must have a system in place to document appointment scheduling times.

    + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

- Hospitals

  (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Amendment Number 4 (cont.)

- Long-Term Care Services:

  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.

- General Optometry Services:

  (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.

  (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- Lab and X-Ray Services:

  (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.

  (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- All other services not specified here shall meet the usual and customary standards for the community.

47. Attachment VII shall be amended by deleting and replacing the following Performance Measures as described below:

18	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment III and V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment III and V

21	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Annually	$5,000 for each full percentage point TENNderCare screening ratio is below 80%

24	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B	Post-Discharge Services Report	Discharged members receive a service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B within seven (7) calendar days of discharge. The standard (benchmark) for compliance will be phased in, according to the following schedule: Year (Data reporting Period) Benchmark January – December 2011 50% January – December 2012 53% January – December 2013 56% January – December 2014 59% January - June 2015 60%	(1) Number of members discharged by length of time between discharge and first service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B, determined for each month (2) Average length of time between hospital discharge and first service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B, determined for each month	Quarterly	$3,000 for each quarter determined to not be in compliance

48. Attachment VII shall be amended by deleting the performance measures based on the "Percentage of priority members who receive a behavioral health service", the "Increase in utilization of supported employment" and the "Annual consumer satisfaction survey administered by TDMHDD".

49. Attachment VIII shall be amended by deleting and replacing Item 107, deleting references to Sections 2.30.4.3, 2.30.4.5 through 2.30.4.8 and 2.30.7.8, renumbering the remaining Items appropriately and deleting and replacing the renumbered Item 156 as follows:

107. Post-Discharge Services Report (see Section 2.30.4.2)

156. Provider Satisfaction Survey Report and CHOICES Provider Satisfaction Survey Report (see Sections 2.30.12.4 and 2.30.12.5)

50. Attachment IX shall be amended by deleting and replacing Exhibits A through D as follows:

ATTACHMENT IX, EXHIBIT A
PSYCHIATRIC HOSPITAL/RTF READMISSION REPORT

The *Psychiatric Hospital/RTF Readmission Report* required in Section 2.30.4.1 shall include, at a minimum, the following data elements:

1. Readmission rates by age group (under 18 and 18 and over) for
   a.) Seven (7) days
   b.) Thirty (30) days

2. Data Analysis

3. Action plan/follow-up

ATTACHMENT IX, EXHIBIT B
POST-DISCHARGE SERVICES REPORT

The *Post-Discharge Services Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number

2. Number and percentage of compliance for kept appointments that occur within seven (7) calendar days of the date of discharge from psychiatric inpatient or residential treatment facility. Appointments that meet compliance include the following:

   A. Intake

   B. Non Urgent Services:
      1) MD Services (Medication Management, Psychiatric Evaluation)
      2) Non MD Services (Psycho- Therapy)
      3) Substance Abuse (SA) (SA IOP, SA therapy)
      4) Psychosocial Rehabilitation (Psych Rehab, Supportive Employment, Supported Housing, Illness Management and Recovery, Peer Support)
      5) Mental Health Case Management

   C. Urgent Services:
      1) MD Services
      2) Non MD Services

3) Substance Abuse (SA IOP) or Detoxification

Amendment Number 4 (cont.)

ATTACHMENT IX, EXHIBIT C
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

The Behavioral Health Crisis Response Report required in Section 2.30.4.3 shall include, at a minimum, the following data elements:

Date:
Agency Name
Total Telephone Contacts
Total Face-to-Face Contacts
Total Face-to-Face Contacts by Payor
Face-to-Face Payor Source: TennCare
Face-to-Face Payor Source: Medicare
Face-to-Face Payor Source: Commercial
Face-to-Face Payor Source: None
Total Face-to-Face Contacts by Location
Face-to-Face Location: Onsite at CMHA
Face-to-Face Location: ER
Face-to-Face Location: Jail
Face-to-Face Location: Other Offsite
Total Face-to-Face Contacts by Disposition
Disposition: Total Admitted to RMHI (acute)
Disposition: Total Admitted to Other Inpt (acute) Includes Dual Dx
GRAND TOTAL PSYCHIATRIC ADMISSIONS
Disposition: Admitted to Crisis Stabilization Unit
Disposition: Admitted to Medically Monitored Detox
Disposition: Referred to Lower Level OP Care
Disposition: Referred to Respite Services
Disposition: Referred to Other Services
Disposition: Assessed / No Need for Referral
Disposition: Consumers Refusing Referral
Total Number of Face-to-Face Contacts for C&A <18 yrs of age
Total Number of Face-to-Face Contacts for C&A 18 to <21 yrs of age
Total Number of Face-to-Face Contacts for Adults 21 yrs and older
Total Number of Behavioral Health Providers notified of Crisis (only if consumer has a provider)
Average Time of Arrival in Minutes
Barriers to Diversion: No Psychiatric Respite Accessible
Barriers to Diversion: No SA/Dual Respite Accessible
Barriers to Diversion: Consumer/Guardian Refused Respite
Barriers to Diversion: 6-404 Signed Prior to Assessment (when consumer could have been diverted if CON not signed)
Barriers to Diversion: Lack of Linkage w/Case Mgr (only if consumer has a CM)
Barriers to Diversion: Refused Referral to CSU
Barriers to Diversion: Other (only for inappropriate admissions and barrier does not fit in any other category)
Total number of successful follow-ups.
Total number of individuals reporting that crisis services were helpful during successful follow-up.

ATTACHMENT IX, EXHIBIT D
INITIAL APPOINTMENT TIMELINESS FOR BEHAVIORAL HEALTH SERVICES REPORT

The *Initial Appointment Timeliness for Behavioral Health Services Report* required in Section 2.30.7.5 shall include, at a minimum, the following data elements:

1. MD Services (Psychiatry):
   a.) Reporting percentage meeting availability standard in ATTACHMENT III: GENERAL ACCESS STANDARDS, by age group (under 18 and 18 and over)
   b.) Reporting average time between intake and initial MD service appointment by age group (under 18 and 18 and over)

2. Outpatient Non-MD Services:
   a.) Reporting percentage meeting availability standard *in* ATTACHMENT V: ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES, by age group (under 18 and 18 and over)
   b.) Reporting average time between intake and initial non-MD outpatient service appointment by age group (under 18 and 18 and over)

   Note: Outpatient services include: Psychosocial Rehabilitation (Psych Rehab, Supportive Employment, Supported Housing, Illness Management and Recovery, Peer Support) Mental Health Case Management, Outpatient Psychotherapy (including intensive outpatient, family/marital therapy, individual and group)

3. Outpatient Substance Abuse Treatment Services (non-Detox)
   a.) Reporting percentage meeting availability standard in ATTACHMENT V: ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES, by age group (under 18 and 18 and over)
   b.) Reporting average time between intake and initial Outpatient Substance Abuse Treatment Services (non-Detox) appointment by age group (under 18 and 18 and over)

4. Data Analysis

5. Action plan/follow-up+

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 January 1, 2011.

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: _____

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

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

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: _____

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 BK
Charles Curtiss, Vice-Chairman, Fiscal Review Committee CC

DATE: June 2, 2010

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 6/2/10)

RFS# 318.66-05608
Department: Finance & Administration/Bureau of TennCare
Contractor: UnitedHealthCare Plan of the River Valley, Inc., AmeriChoice – West Tennessee Region
Summary: The vendor is responsible for the provision of medical and behavioral health services to TennCare enrollees in West Tennessee. The proposed amendment adds language to comply with the Annual Coverage Assessment Act of 2010; creates new method for adjusting the long-term care component of the base capitation rate; and adds new liquidated damages.
Maximum liability: $1,486,132,800
Maximum liability w/amendment: $1,486,132,800

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

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

May 18, 2010

RECEIVED
MAY 18 2010
FISCAL REVIEW

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

Attention: Ms. Leni Chick

RE: Bureau of TennCare Contract Amendments

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)	FA-02-14632-23
AMERIGROUP Tennessee, Inc.	FA-07-16936-06
UnitedHealthCare Plan of River Valley, Inc.	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.

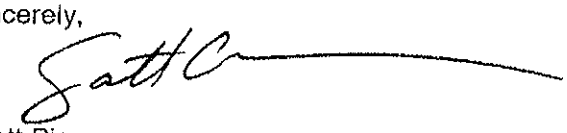
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-03
Volunteer State Health Plan (West Region)	FA-08-24978-03
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-03
Volunteer State Health Plan (East Region)	FA-08-24983-03

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,



Scott Pierce
Chief Financial Officer

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

NON-COMPETITIVE AMENDMENT REQUEST:

APPROVED
Commissioner of Finance & Administration

1) RFS #	318.66-056-08
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 West Tennessee Region
4) Contractor :	UnitedHealthCare Plan of the River Valley, Inc. (AmeriChoice)
5) Contract #	FA-08-24979-00
6) Contract Start Date :	May 19, 2008
7) CURRENT Contract End Date : (If ALL options to extend the contract are exercised)	June 30, 2012
8) CURRENT Maximum Cost : (If ALL options to extend the contract are exercised)	$ 1,486,132,800.00
PROPOSED AMENDMENT INFORMATON	
9) Amendment #	3
10) Amendment Effective Date : (attached explanation required if < 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, 2012
12) PROPOSED Maximum Cost : (If ALL options to extend the contract are exercised)	$ 1,486,132,800.00
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) 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; (5) LTC capitation payment rates for use upon implementation of the CHOICES Program in East and West TN; and (6) various housekeeping clarifications including numbering and typos. There is no term extension or additional funding associated with this amendment.

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, updates to Long Term Care reporting within the contract , LTC capitation payment rates for use upon implementation of the CHOICES Program in East and West TN, as well as other contract updates.

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

Richard L. Bartsh, M.D.
President

United Healthcare Plan of River Valley, Inc.
1300 River Drive
Moline, IL 61265

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 West Tennessee Region. This amendment adds language changes and clarifications to existing competitively procured contract.

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.

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 MDGoetz II 5/10/10

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	507-6415
*Original Contract Number:	FA-08-24979-00	*Original RFS Number:	318.66-056-08
Edison Contract Number: *(if applicable)*	N/A	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	May 19, 2008	*Current End Date:	June 30, 2012

Current Request Amendment Number: *(if applicable)*	3
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. (West Region)
*Current Maximum Liability:	$1,486,132,800.00

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

FY: 2008	FY: 2009	FY: 2010	FY: 2011	FY	FY
$0.00	$327,533,200.00	$491,299,800.00	$667,299,800	$	$

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

FY: 2008	FY: 2009	FY: 2010	FY:	FY	FY
$0.00	$267,572,091.06	$ 414,680,235.41	$	$	$

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:	$436,920,932.00	Federal:	$1,049,211,868.00
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 - September 1, 2009	This amendment provided compliance with Mental Health Parity Act, provided clarification language to the contract, streamlined reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #2 – March 1, 2010	This amendment provided compliance with Long Term Care Community Choices Act of 2008 for the provision of home and community based services and restructuring the long-term care system in Tennessee.

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

Supplemental Documentation Required for Fiscal Review Committee

Request for Proposal (RFP) process. No other options are applicable.					
Proposed Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:

AMERICHOICE – West

FY 2010

Pre-Edison Payments:

Vendor Invoice	Invoice Date	Voucher	TCS BHO PAYMENTS	18A MCO PAYMENTS	Total
AMERICHOICE	WEST (030)				
RA100650629	6/29/2009	100650629		33,377,136.05	[redacted]
RA100650632	6/29/2009	100650632	2,679,295.95		[redacted]
RA100686182	8/4/2009	100686182		33,141,928.70	[redacted]
RA100686185	8/4/2009	100686185	2,959,786.13		[redacted]
RA100714796	9/1/2009	100714796	2,705,047.53		[redacted]
RA100714793	9/1/2009	100714793		32,292,884.47	[redacted]
Subtotal:			8,344,129.61	98,811,949.22	107,156,078.83

Edison Payments:

Unit	Voucher ID	Invoice #	Vendor Name	Amount Pd	Fy/mn Date
	Americhoice West (030)				
31865	00006783	100741320	Americhoice	35,689,864.26	10/5/2009
31865	00006786	100741323	Americhoice	2,765,854.13	10/5/2009
31865	00015654	100776111	Americhoice	32,766,310.96	11/6/2009
31865	00015657	100776114	Americhoice	2,762,098.49	11/6/2009
31865	00022039	100797595	Americhoice	33,427,291.62	12/7/2009
31865	00022042	100797598	Americhoice	2,685,389.41	12/7/2009
31865	00018419	2008-01	Americhoice	1,248,854.37	11/19/2009
31865	00016960	2008-02	Americhoice	360,797.32	11/16/2009
31865	00016959	2008-03	Americhoice	181,054.69	11/16/2009
			Total Qtr 2	111,887,515.25	
030					
31865	00051201	100841167	Americhoice	33,367,948.02	1/8/2010
31865	00051204	100841170	Americhoice	2,841,012.86	1/8/2010
31865	00068251	100869735	Americhoice	43,710,143.57	2/5/2010
31865	00068254	100869738	Americhoice	2,178,842.45	2/5/2010
31865	00086762	100898572	Americhoice	34,557,253.26	3/5/2010
31865	00086765	100898575	Americhoice	2,658,621.88	3/5/2010
			Total Qtr 3	119,313,822.04	

AMERICHOICE – WEST
FY 2010 Payments Continued

030					
31865	00104916	100927982	Americhoice	35,137,803.71	4/2/2010
31865	00104919	100927985	Americhoice	2,828,514.72	4/2/2010
31865	00125594	100963515	Americhoice	35,825,443.72	5/7/2010
31865	00125597	100963518	Americhoice	2,531,057.14	5/7/2010
			Total Qtr 4	76,322,819.29	

FY 2010 TOTAL: $414,680,235.41

[redacted] WEST

PAYMENT DATE	NET PAYMENT	NET PAYMENT	Total Capitation
4-Nov-08	29,960,012.13	2,082,051.39	**32,042,063.52**
5-Dec-08	27,732,784.26	2,169,443.38	**29,902,227.64**
1-Jan-09	30,456,502.53	2,573,150.89	**33,029,653.42**
3-Feb-09	31,312,367.94	2,407,160.81	**33,719,528.75**
6-Mar-09	31,261,339.12	2,295,182.31	**33,556,521.43**
1-Apr-09	31,270,404.87	2,787,721.77	**34,058,126.64**
28-Apr-09	31,698,603.12	2,681,946.71	**34,380,549.83**
2-Jun-09	34,013,725.57	2,869,694.26	**36,883,419.83**
Total 2009	**247,705,739.54**	**19,866,351.52**	**267,572,091.06**

ATTACHMENT XII

CAPITATION RATES
WEST GRAND REGION
EFFECTIVE November 1, 2008 through June 30, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	**Age Under 1**	**$ 469.10**
	Age 1 - 13	**$ 97.24**
	Age 14 - 20 Female	**$ 185.88**
	Age 14 - 20 Male	**$ 84.25**
	Age 21 - 44 Female	**$ 275.89**
	Age 21 - 44 Male	**$ 132.34**
	Age 45 – 64	**$ 349.07**
	Age 65 +	**$ 307.07**
Uninsured/Uninsurable	**Age Under 1**	**$ 469.10**
	Age 1 - 13	**$ 71.11**
	Age 14 - 19 Female	**$ 96.45**
	Age 14 – 19 Male	**$ 78.47**
Disabled	**Age < 21**	**$ 780.67**
	Age 21 +	**$ 635.60**
Duals/Waiver Duals	**All Ages**	**$ 69.56**
State Only & Judicials	**All Ages**	**$ 558.22**
Priority Add-On	**All Ages**	**$ 243.05**

CONTRACT NOT PAID THROUGH EDISON
CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
318.66-056-08	FA-08-24979-03

State Agency	State Agency Division
Department of Finance and Administration	Bureau of TennCare

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare of the River Valley, Inc.	☐ C- or ☒ V-

Service Description

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

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
May 19, 2008	June 30, 2012	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	$117,459,956.00	$210,073,244.00			$327,533,200.00
2010	$122,407,345.00	$368,892,455.00			$491,299,800.00
2011	$197,053,631.00	$470,246,169.00			$667,299,800.00
TOTAL:	$436,920,932.00	$1,049,211,868.00			**$1,486,132,800.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2008	0.00	0.00
2009	$327,533,200.00	0.00
2010	$491,299,800.00	0.00
2011	$667,299,800.00	0.00
TOTAL:	**$1,486,132,800.00**	**0.00**
End Date:	**6/30/2012**	**6/30/2012**

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 3
WEST GRAND REGION
CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA- 08-24979-00

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

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.

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 August 1st, 2010 through the completion of the 2011 open enrollment period for enrollees who were enrolled in CHOICES on August 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 August 1, 2010 through March 31, 2011 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 March 2012, after the completion of the open enrollment period for 2012. This process will compare the effect of net transfers as compared to the mix before the 2012 open enrollment period.

3.4.3.7.1.3 This adjustment will be budget neutral to the state.

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 August 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 (½) 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:

A.18	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)		$500 per day beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided
A.19	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)		$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
A.20	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		$500 per deficient plan of care

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 3 (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

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

DATE: 6/29/10

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____
Sonya Nelson
President and Chief Executive Officer

DATE: 6/28/2010

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: 7/8/10

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
Justin P. Wilson
Comptroller

DATE: 7/22/10