CONTRACT #7
RFS # 318.66-051
FA # 07-16937
Edison # 29634

Department of Finance and Administration
Health Care Finance and Administration
Bureau of TennCare

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

October 31, 2013

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Managed Care Contract Amendments (7)
BlueCross Blue Shield – Cover Tennessee Contract
Policy Studies, Inc, Amendment #9 – Cover Tennessee Contract

Dear Mr. Geise:

The Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), is submitting for consideration by the Fiscal Review Committee amendments to the Managed Care Organization (MCO) contracts. These contracts provide medical and behavioral health services to eligible TennCare enrollees. The proposed amendments contain language changes regarding the role of the Fiscal Employer Agent, the Supports Broker, and the MCO for CHOICES members participating in Consumer Direction, as well as clarifications regarding the CHOICES program and updates the contract to include current capitation rates. The term for the East/West and Volunteer State Health Plan - TennCare Select contracts have been extended and funding added to all amendments to support the continuation of services through current end date. TennCare has released a Request for Proposal to competitively procure statewide MCO contracts with a projected award date of late December.

Volunteer State Health Plan – TennCare Select
AMERIGROUP Tennessee, Inc
UnitedHealthCare Plan of the River Valley, Inc. – Middle
UnitedHealthCare Plan of the River Valley, Inc. – West
Volunteer State Health Plan – West
UnitedHealthCare Plan of the River Valley, Inc. – East
Volunteer State Health Plan – East

In addition to the MCO amendments, HCFA is submitting amendment #9 to Policy Studies, Inc., the competitively procured contract for eligibility determination, application processing, applicant outreach and enrollee retention services for the CoverKids program. The eligibility determination services provided by this Contractor will be transitioning through Calendar year 2014 to the new competitively procured TennCare Eligibility Determination System (TEDS). This amendment provides a mechanism for the State to ensure the continuation of eligibility services for an additional period of time to allow sufficient time for transition to TEDS.

Additionally, we are submitting a new contract with BlueCross Blue Shield for the delivery of CoverKids and AccessTN, collectively "Cover Tennessee," the self-funded health plan services. These services include administrative services, provider network development and maintenance, eligibility and enrollment, premium equivalent billing and collections, case and care management, disease management, medical benefits, pharmacy benefits, behavioral health benefits customer service, claims adjudication and adjustment, appeals services and financial and program reporting for both programs. The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including AccessTN (state high risk pool) and CoverKids (federal Children's Health Insurance Program).

The Department of Finance and Administration, Division of Health Care Finance and Administration, respectfully submits the above referenced amendments and new contract for consideration and approval by the Fiscal Review Committee.

Sincerely,

Casey Dungan
Chief Financial Officer

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	29634	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	16
Proposed Amendment Effective Date: *(if applicable)*	December 31, 2013
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	October 31, 2013
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$6,313,567,211.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00
FY: 2013	**FY: 2014**				
$989,205,835.00	$989,205,835.00				

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$848,507,847.90
FY: 2013	**FY: 2014**				
$932,619,369.48	$321,997,822.42				

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.

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:	$2,067,717,045.00	Federal:	$4,245,850,166.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.

Supplemental Documentation Required for Fiscal Review Committee

Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.
Amendment #10 – January 1, 2012	Program Integrity Updates, HIPAA/HITECH clarifications; CHOICES updates; Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; Increase funding to support the services for this contract for FY '12 and FY '13 based on actual expenditures
Amendment #11 – March 1, 2012	Added language to clarify that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility.
Amendment #12 – July 1, 2012	Added requirements for the Contractor regarding the implementation and operation of CHOICES Group 3, language to clarify that QM/QI reporting must be specific to TennCare and not combined with other state or commercial programs, Program Integrity language to clarify PI Investigators be designated by plan, SSA Data Security language added in accordance with our agreement with SSA, and Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. No additional funding is required relative to this amendment.
Amendment #13 – January 1, 2013	(1) Replaces Disease Management requirements with Population Health requirements; (2) Clarification regarding the implementation of CHOICES 3 requirements; (3) Clarification language as requested by CMS regarding TPL and PETI; (4) Include requirement to support CMS require PCP rate increase for 2013/2014; (5) Include requirement to participate and implement initiatives to capture Prenatal and Postnatal visit data; (6) Coordination requirements for MCOs regarding DSNPs; (7) Updates the transportation requirements to reflect current reporting needs and support audit efforts, and (8) provides contract funding for FY '14.
Amendment #14 – March 15, 2013	Added language requested by the Center for Medicare and Medicaid Services (CMS) regarding the Primary Care Rate Bump Final Rule as required by the Affordable Care Act.
Amendment #15 – June 1, 2013	Added language requirements surrounding CHOICES, member material and Outreach Evaluation of MCO outreach plans, and additional changes to update references regarding Individuals with Developmental Disabilities.

Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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.

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.

Supplemental Documentation Required for Fiscal Review Committee

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.

CONTRACT SUMMARY SHEET

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-15

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
TOTAL:	$ 2,067,717,045.00	$ 4,245,850,166.00	$ -	$ -	**$ 6,313,567,211.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ 989,205,835.00	
TOTAL:	**$ 6,313,567,211.00**	$ -
End Date	December 31, 2014	

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix FA or GR)

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

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

[X] RFP	[ ] Competitive Negotiation	[ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation	[ ] Negotiation w/ Government(eg.ID,GG,GU)	[ ] Other

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

UnitedHealthCare Plan (Americhoice) - Middle - Edison #29634

FY 2014

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00731845	0000021799	76,097,143.68	7/5/2013
31865	00747060	0000021799	90,305,323.97	8/2/2013
31865	00765535	0000021799	78,244,858.91	9/6/2013
			244,647,326.56	
31865	00780227	0000021799	77,350,495.86	10/4/2013
			77,350,495.86	

FY 2014 TOTAL $ 321,997,822.42

UnitedHealthCare Plan (Americhoice) - Middle - Edison #29634

FY 2013

Unit	Voucher ID	Vendor ID		Amount Pd	Pymnt Date
31865	101696065	0000021799	$	77,600,771.38	7/6/2012
31865	101723402	0000021799	$	79,380,930.51	8/3/2012
31865	101758287	0000021799	$	77,957,765.92	9/7/2012
				234,939,467.81	
31865	00583536	0000021799		77,555,656.30	10/5/2012
31865	00590779	0000021799		44,000.00	10/19/2012
31865	00598074	0000021799		78,885,213.03	11/2/2012
31865	00615111	0000021799		77,726,345.44	12/7/2012
				234,211,214.77	
31865	00628398	0000021799		77,085,082.13	1/4/2013
31865	00643397	0000021799		75,386,077.57	2/1/2013
31865	00660941	0000021799		77,184,578.15	3/1/2013
31865	00665243	0000021799		85,000.00	3/8/2013
				229,740,737.85	
31865	102003906	0000021799		26,500.00	5/31/2013
31865	101950975	0000021799		76,532,533.66	4/5/2013
31865	102010616	0000021799		76,863,800.33	6/7/2013
31865	101976788	0000021799		80,305,098.14	5/3/2013
31865	2013-01M	0000021799		16.92	4/3/2013
				233,727,949.05	

FY 2013 TOTAL $ 932,619,369.48

UnitedHealthCare Plan (Americhoice) - Middle - Edison #29634

FY 2012

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00357932	0000021799	80,164,116.78	8/1/2011
31865	00357935	0000021799	1,749.12	8/1/2011
31865	00373132	0000021799	66,259,994.41	9/2/2011
31865	00373135	0000021799	4,290.68	9/2/2011
			146,430,150.99	
31865	00390204	0000021799	68,500,422.24	10/7/2011
31865	00390207	0000021799	1,970.72	10/7/2011
31865	00396234	0000021799	16,338,030.88	10/17/2011
31865	00396235	0000021799	189,155.42	10/17/2011
31865	00404008	0000021799	77,882,668.64	11/4/2011
31865	00404011	0000021799	1,159.98	11/4/2011
31865	00417176	0000021799	66,848,857.76	12/5/2011
31865	00417179	0000021799	37.42	12/5/2011
			229,762,303.06	
31865	101519377	0000021799	76,652,274.04	1/6/2012
31865	101547443	0000021799	84,528,169.47	2/3/2012
31865	101574349	0000021799	78,374,720.09	3/2/2012
31865	101538873	0000021799	12,350.00	2/1/2012
			239,567,513.60	
31865	101608051	0000021799	77,495,120.45	4/5/2012
31865	101621414	0000021799	1,300.00	4/23/2012
31865	101628167	0000021799	12,000.00	4/27/2012
31865	101635082	0000021799	79,019,045.16	5/4/2012
31865	101662448	0000021799	76,220,414.64	6/1/2012
			232,747,880.25	

FY 2012 TOTAL $ 848,507,847.90

UnitedHealthCare Plan (Americhoice) - Middle - Edison #29634
FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL $ 1,051,885,932.05

UnitedHealthCare Plan (Americhoice) - Middle - Edison #29634

FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL $ 729,187,454.49

UnitedHealthCare Plan (Americhoice) – Middle

Edison # 29634

FY2007 – FY2008 – FY2009

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

cy13-2795

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED

Michael F. Perry

CENTRAL PROCUREMENT OFFICE

Request Tracking #	31866-00051
Procuring Agency	Department of Finance and Administration Bureau of TennCare
Contractor	UnitedHealthCare Plan of the River Valley, Inc.
Contract #	FA-07-16937-00
Proposed Amendment #	16
Edison ID #	29634

Contract Begin Date	August 15, 2006
Current Contract End Date *– with ALL options to extend exercised*	December 31, 2014
Proposed Contract End Date *– with ALL options to extend exercised*	December 31, 2014
Current Maximum Contract Cost *– with ALL options to extend exercised*	$6,313,567,211.00
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	$6,808,170,129.00
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	X Not Applicable ☐ Attached
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	X Not Applicable ☐ Attached
Human Resources Support *– state employee training service*	X Not Applicable ☐ Attached

Explanation Need for the Proposed Amendment

This competitively procured contract provides medical and behavioral health services to TennCare enrollees. The proposed amendment contains the following language updates: (1) Clarifications regarding the role of the Fiscal Employer Agent, the Supports Broker, and the MCO for CHOICES members participating in Consumer Direction, (2) Deletion of all CHOICES language pertaining to Immediate Eligibility, (3) Clarifications regarding MCO responsibilities concerning member transitions

Request Tracking #	31866-00051

between CHOICES groups, and when a member is admitted for short-term nursing facility stay or has an approved Pre-Admission Evaluation (level of care determination) with an end date, (4) Clarify coordination requirement with DBM for Wavier Programs (5) Quality Clarifications (Population Health, Outreach reporting, timeframe clarification for loading providers/delegated credentialing, (6) Payment Reform Requirements, (7) Update contract to include current capitation rates, (8) Housekeeping (appropriate references to Family Support Services/Peer Recovery Services, etc.), and (9) provide FY '15 funding for final six (6) months of contract term.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract provides medical and behavioral health services to TennCare enrollees. The proposed amendment contains language changes regarding the role of the Fiscal Employer Agent, the Supports Broker, and the MCO for CHOICES members participating in Consumer Direction, clarifications regarding the CHOICES program, other contract clarifications regarding MCO responsibilities , update the contract to include current capitation rates, and provide funding provided for final six (6) months of contract term. TennCare has released a Request for Proposal to identify new MCO contracts statewide. The Bureau of TennCare respectfully requests review and approval of this contract amendment.

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

CONTRACT SUMMARY SHEET

021406

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-16

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
2015	$ 172,789,530.00	$ 321,813,388.00			$ 494,602,918.00
TOTAL:	$ 2,240,506,575.00	$ 4,567,663,554.00	$ -	$ -	**$ 6,808,170,129.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ 989,205,835.00	
2015		$ 494,602,918.00
TOTAL:	**$ 6,313,567,211.00**	**$ 494,602,918.00**
End Date	December 31, 2014	

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix: FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg,ID,GG,GU) [ ] Other

AMENDMENT NUMBER 16
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. Section 1 shall be amended by modifying, deleting and adding the following definitions:

Back-up Plan – A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or non-residential CHOICES HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA will assist as needed with the development and verification of the initial back-up plan for consumer direction. The care coordinator shall be responsible for assistance as needed with implementing the back-up plan and for updating and verifying the back-up plan on an ongoing basis.

Supports Broker – An individual assigned by the FEA to each CHOICES member participating in consumer direction who assists the member/representative as needed in performing certain employer of record functions as follows: developing job descriptions; recruiting, interviewing, and hiring workers; member and worker enrollment in consumer direction and consumer direction training; and developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care. . The supports broker shall also assist the member as needed with developing and verifying the initial back-up plan for consumer direction. The supports broker collaborates with the member's care coordinator, as appropriate. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.

Wellness – An approach to health care that emphasizes not merely the absence of disease or infirmity but the pursuit of optimum health. It is an active process of helping members become aware of and make choices that will help them to achieve a healthy and more fulfilling life. Wellness includes preventing illness, prolonging life, and improving quality of life, as opposed to focusing solely on treating diseases. Wellness is a condition of good physical and mental health, especially when accomplished and maintained by personal choice and action, including proper diet, exercise, and health habits.

2. Section 2.6.1.3 shall be amended by deleting and replacing the "SERVICE"/"BENEFIT LIMIT" for Dental Services as follows:

Dental Services	**Dental Services shall be provided by the Dental Benefits Manager or in some cases, through an HCBS waiver program for persons with intellectual disabilities (i.e., mental retardation).** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM or though an HCBS waiver program for persons with intellectual disabilities (i.e., mental retardation).

3. Section 2.6.1.5 shall be amended by deleting the existing Section 2.6.1.5.3 and renumbering the remaining Section accordingly, including any references thereto.

4. The renumbered Section 2.6.1.5.3.1 shall be amended by adding the phrase "review all requests for short-term NF stays and shall" as follows:

2.6.1.5.3.1 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

5. The renumbered Section 2.6.1.5.3.1.2 shall be deleted and replaced as follows:

2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

6. Section 2.7.2.7 shall be deleted and replaced as follows:

2.7.2.7 Psychiatric Rehabilitation Services

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

7. Section 2.7.4.2.1 shall be deleted and replaced as follows:

2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; all proposed community/health education events unrelated to TENNderCare; and a system approved by TENNCARE for not only documenting and evaluating their events within thirty (30) days of occurrence, but also reporting on their evaluations in the TENNderCare/EPSDT Quarterly Reports. An Annual Evaluation of the Plan shall be due no later than ninety (90) days following the end of a calendar year in a format approved by TENNCARE. This evaluation must include an appraisal of the objectives in the Plan and an assessment of the events conducted in the previous year in a format approved by TENNCARE.

8. Section 2.7.6.2.10.2 shall be deleted and replaced as follows:

2.7.6.2.10.2 The CONTRACTOR shall participate in a minimum of fifteen (15) interagency meetings with representatives from state agencies or community-based organizations per quarter, to either educate them on services available through the CONTRACTOR or to develop outreach and educational initiatives. Collaborative activities should include those designed to reach enrollees with limited English proficiency, low literacy levels, behavioral health needs and special health care needs or who are pregnant.

9. Section 2.7.6.10.2 shall be deleted and replaced as follows:

2.7.6.10.2 The CONTRACTOR shall participate in a minimum of fifteen (15) interagency meetings with representatives from state agencies or community-based organizations per quarter, to either educate them on services available through the CONTRACTOR or to develop outreach and educational initiatives. Collaborative activities should include those designed to reach enrollees with limited English proficiency, low literacy levels, behavioral health needs and special health care needs or who are pregnant.

10. Section 2.8.2.1 shall be amended by adding a new Section 2.8.2.1.1 as follows and renumbering the existing Sections accordingly.

2.8.2.1.1 The CONTRACTOR shall make reasonable attempts to assess member's health risk utilizing the appropriate common HRA approved by the Bureau and Population Health staff. The information collected from these mini assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

11. The renumbered Section 2.8.2.1.3.1 shall be deleted and replaced as follows:

2.8.2.1.3.1 All members identified as Level 1, through predicative modeling, and not pregnant are eligible for the Health Risk Management Program. At a minimum, the CONTRACTOR shall enroll members with chronic diseases that are prevalent in a significant number of members, or members with other chronic diseases utilizing significant health resources in their regional population.

12. The renumbered Section 2.8.2.1.3 shall be amended by adding a new Section 2.8.2.1.3.3 as follows:

2.8.2.1.3.3 The CONTRACTOR shall place all level 2 members who cannot be contacted by the process referenced in Section 2.8.4.5.2 of this Agreement, or chose not to enroll in a level 2 program, in Level 1 programs.

13. The renumbered Section 2.8.2.1.4 shall be deleted and replaced as follows:

2.8.2.1.4 **Level 2** – Members eligible to participate at this Level shall be determined by predictive modeling identifying the top three percent (3%) of members, excluding level 2 maternity members, to be most at risk for adverse health outcomes, and/or by referrals or health risk assessments.

14. Section 2.8.4.6.1 shall be amended by deleting and replacing the reference to "Section 2.8.4.5.1" with "Section 2.8.4.5.2".

15. Section 2.8.11.5 shall be deleted and replaced as follows:

2.8.11.5 The CONTRACTOR shall submit, through the current secure system, a list in Comma Separated Value (CSV) format consisting of the name, ID, DOB, stratification or all risk levels and the corresponding dates of eligibility for the level and program assignments for all MCO members.

16. Section 2.8.12 shall be deleted and replaced as follows:

2.8.12 **Special Projects**

2.8.12.1 As appropriate, the CONTRACTOR's Population Health staff shall participate in a collaborative MCO/TennCare workgroup to evaluate the common standard new enrollee assessments and address innovative ways to improve member completion rates.

2.8.12.2 The CONTRACTOR shall conduct at least two rapid cycle improvement projects annually. One rapid cycle improvement project shall address increasing member engagement rates in the High Risk opt in level of Population Health programs. The second rapid cycle engagement project shall address engaging members to make behavioral changes such as weight loss, or smoking cessation. The project plans are to be reported in the quarterly report before implementation. The projects should then be conducted with the results to be reported in the next Population Health Quarterly Report.

17. Sections 2.9.5 through 2.9.5.6 shall be deleted and replaced with "Left Blank Intentionally"

2.9.5 **Left Blank Intentionally**

18. Section 2.9.6.2.4.1 shall be deleted and replaced as follows:

2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall reimburse such services in accordance with the level of reimbursement for nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. Reimbursement for such services shall be from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) provide continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) provide continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

19. Section 2.9.6.2.4.4 and 2.9.6.2.4.5 shall be deleted and replaced as follows:

2.9.6.2.4.4 For purposes of the CHOICES program, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process

claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.

2.9.6.2.4.5 For CHOICES members approved by TENNCARE for Level II reimbursement of nursing facility services, the CONTRACTOR shall be responsible for monitoring the member's continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when such skilled and/or rehabilitative services are no longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care (i.e., reimbursement) for nursing facility services (see also Section 2.14.1.15).

20. Sections 2.9.6.2.5.1, 2.9.6.2.5.2, 2.9.6.2.5.3, and 2.9.6.2.5.10 shall be deleted and replaced as follows:

2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services that are covered in CHOICES, the CONTRACTOR shall, immediately upon notice of the member's enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider.

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 CHOICES HCBS specified in the plan of care (i.e., assistive technology)..

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 CHOICES HCBS.

2.9.6.2.5.10 As part of the face-to-face visit for members in CHOICES Group 2 or Group 3, the care coordinator shall review, and revise as necessary, the member's risk assessment, and

develop a risk agreement, which shall document identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. The risk agreement shall be signed and dated by the member and shall also be signed by the care coordinator, attesting that such risks and strategies have been discussed with the member or his/her representative prior to their decision to accept such risk.

21. Section 2.9.6.3.9 shall be amended by deleting and replacing the references to "DHS" with "TENNCARE".

22. Sections 2.9.6.3.20.1 and 2.9.6.3.20.2 shall be deleted and replaced as follows:

2.9.6.3.20.1 For purposes of the CHOICES program, service authorizations for CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the plan of care, including the schedule at which services are needed and any updates to the plan of care and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

2.9.6.3.20.2 Notwithstanding the address and/or phone number in the 834 file, for purposes of the EVV system (see Section 2.9.6.12.5.), the CONTRACTOR shall use the member's address or phone number or appropriate alternative phone number as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5), through EVV alert monitoring or other member contacts for all HCBS that will be logged into the EVV system.

23. Section 2.9.6.5.1.1 shall be amended by adding the words "overall wellness" as follows:

2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a care coordinator shall conduct any needs assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. This assessment may include identification of targeted strategies related to improving overall wellness, health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increasing and/or maintaining functional abilities, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit. The care coordinator shall ensure coordination of the member's physical health, behavioral health, and long-term care needs and shall assess at least annually the member's potential for an interest in transition to the community. For children under the age of 21 in nursing facilities, this shall include explanation to the member or his parent or authorized representative, as applicable, of benefits available

pursuant to EPSDT, including medically necessary benefits such as home health or private duty nursing that may be provided in the community as an alternative to nursing facility care.

24. Section 2.9.6.5.2.2 shall be deleted and replaced as follows:

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive needs assessment shall assess: (1) the member's overall wellness including physical, behavioral, functional, and psychosocial needs, and an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment; (2) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; and (3) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community and to delay or prevent the need for institutional placement.

25. Section 2.9.6.5.2.4 shall be amended by adding a new Section 2.9.6.5.2.4.1 as follows:

2.9.6.5.2.4.1 For CHOICES Group 3 members whose change in needs result in a transition to Group 2, the CONTRACTOR shall request the transition by submitting a PAE to TENNCARE and upon receiving approval for the member's enrollment into Group 2, ensure that any new service(s) specified in the plan of care are initiated within five (5) business days, except when such service(s) may be initiated only upon completion of an adverse action pertaining to another service such that advance notice is required. In such case, the new service(s) shall be initiated upon expiration of the advance notice period or upon resolution of any timely filed appeal requiring continuation of the existing benefits.

26. Section 2.9.6.6.1.1 shall be amended by adding the words "overall wellness," as follows:

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve overall wellness, health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's CHOICES file.

27. Section 2.9.6.6.2.4 shall be deleted and replaced as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, the schedule at which such care is needed, and the address or phone number(s) that will be used to log visits into the EVV system, as applicable; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

28. Section 2.9.6.6.2.5.1 shall be amended by adding the words "overall wellness," as follows:

2.9.6.6.2.5.1 Description of the member's overall wellness, current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs;

29. Section 2.9.6.6.2.5.6 shall be amended by adding the word "wellness," as follows:

2.9.6.6.2.5.6 A person-centered statement of goals, objectives and desired wellness, health, functional and quality of life outcomes for the member and how CHOICES services are intended to help the member achieve these goals;

30. Section 2.9.6.6.2.6.4 shall be deleted and replaced as follows:

2.9.6.6.2.6.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; however, all schedule changes must be member-initiated; 3) changes in the member's current address and phone number(s) or the phone number(s) that will be used to log visits into the EVV system; 4) the end of a member's participation in MFP at the

conclusion of his 365-day participation period; or 5) instances as permitted pursuant to TennCare policies and protocols. Documentation of such changes shall be maintained in the member's records.

31. Sections 2.9.6.6.2.8 and 2.9.6.6.2.8.1 shall be deleted and replaced as follows:

2.9.6.6.2.8 Within five (5) business days of completing a reassessment of a member's needs, the member's care coordinator shall update the member's plan of care as appropriate, and the CONTRACTOR shall authorize and initiate CHOICES HCBS in the updated plan of care, except when such service(s) may be initiated only upon completion of an adverse action such that advance notice is required. In such case, HCBS in the updated plan of care shall be initiated upon expiration of the advance notice period or upon resolution of any timely filed appeal requiring continuation of the existing benefits. The CONTRACTOR shall comply with requirements for service authorization in Section 2.9.6.2.5.12, change of provider in Section 2.9.6.2.5.13, and notice of service delay in Section 2.9.6.2.5.14.

2.9.6.6.2.8.1 Within three (3) business days of updating the member's plan of care, the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the FEA, as applicable, and to other providers authorized to deliver care to the member. Relevant information shall include any information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to any changes in the tasks and functions to be performed.

32. Section 2.9.6.6.2.9 shall be deleted and replaced as follows:

2.9.6.6.2.9 The member's care coordinator shall inform each member of his/her eligibility end date and educate members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members receiving CHOICES HCBS may be contacted by TENNCARE or its designee to offer assistance with the redetermination process (e.g., collecting appropriate documentation and completing the necessary forms), when such process has not been completed timely and the member is at risk of losing eligibility.

33. Section 2.9.6.8.26 shall be amended by deleting the phrase "(e.g., DHS)".

34. Section 2.9.6.8.26.2 shall be deleted and replaced as follows:

2.9.6.8.26.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF and of all NF discharges and transfers between NFs; and b) receiving NFs of all applicable level of care information when a member is transferring between NFs.

35. Section 2.9.6.9.1.1.5 shall be amended by deleting and replacing the word "DHS" with "TENNCARE".

36. Section 2.9.6.9.1.1 shall be amended by adding a new Section 2.9.6.9.1.1.7 as follows:

2.9.6.9.1.1.7 Develop protocols and processes for care coordinators to escalate and report as appropriate concerns regarding NF quality.

37. Section 2.9.6.9.2.1.5 shall be deleted and replaced as follows:

2.9.6.9.2.1.5 Document and confirm the applicant's current address and phone number(s) or appropriate alternative phone number(s) that the member's service provider will use to log visits into the EVV system, and assist the member in updating his or her address with TENNCARE or the Social Security Administration, if applicable.

38. Section 2.9.6.9.2.1.17.2 shall be deleted and replaced as follows:

2.9.6.9.2.1.17.2 Significant change in health and/or functional status, including any change that results in the member's level of care and transition between CHOICES Groups, e.g., transitions from Group 2 to Group 3 or Group 3 to Group 2;

39. Section 2.9.6.9.2.1 shall be amended by adding a new Section 2.9.6.9.2.1.18 as follows and renumbering the existing Section accordingly including any references thereto.

2.9.6.9.2.1.18 When, due to a change in circumstances, a member is approved for transition from Group 2 to Group 3 or from Group 3 to Group 2, within five (5) business days of scheduled initiation of new or modified CHOICES HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that new or modified services are being provided in accordance with the plan of care, and that the member's needs are being met (such initial contact may be conducted by phone).

40. Section 2.9.6.9.3.1 shall be amended by adding new Sections 2.9.6.9.3.1.2 and 2.9.6.9.3.1.7 as follows and renumbering the remaining Sections accordingly including any references thereto.

2.9.6.9.3.1.2 Track and monitor all members whose LOC eligibility has an expiration date and ensure that a LOC reassessment (i.e., PAE) is completed and submitted to TENNCARE at least eight (8) business days prior to expiration of the member's current LOC eligibility segment, including all required supporting documentation needed to appropriately determine the member's LOC eligibility going forward.

2.9.6.9.3.1.7 Assist members in establishing and achieving personal wellness goals.

41. The renumbered Section 2.9.6.9.3.1.11 shall be deleted and replaced as follows:

2.9.6.9.3.1.11 When the CONTRACTOR is facilitating a member's admission to a nursing facility, ensure that all PASRR requirements have been met prior to the member's admission to a nursing facility, including a PASRR level I screening and as applicable, a level II PASRR evaluation, whether the screening is completed by the nursing facility, the CONTRACTOR, or another entity.

2.9.6.9.3.1.11.1 The CONTRACTOR shall coordinate with the nursing facility to help ensure that current information regarding the member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination.

42. Section 2.9.6.9.4.3.5 shall be amended by adding a new Section 2.9.6.9.4.3.5.1 as follows:

2.9.6.9.4.3.5.1 When a member is approved for transition from Group 2 to Group 3 or from Group 3 to Group 2, within five (5) business days of scheduled initiation of new or modified CHOICES HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that new or modified services are being provided in accordance with the plan of care, and that the member's needs are being met (such initial contact may be conducted by phone).

43. Section 2.9.6.9.4.3.9 shall be amended by deleted the phrase "or Group 3" so that the amended Section reads as follows:

2.9.6.9.4.3.9 Members in CHOICES Group 2 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member's MFP participation period, minimum contacts shall be as described in 2.9.6.9.4.3.7 unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, or based on a significant change in circumstances (see Sections 2.9.6.9.2.1.17. and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

44. Section 2.9.6.10.3.3 shall be amended by adding the phrase "or Group 3, as applicable" at the end of the existing text.

2.9.6.10.3.3 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2 or Group 3, as applicable.

45. Section 2.9.6.10.5 shall be amended by adding a new Section 2.9.6.10.5.1 as follows:

2.9.6.10.5.1 The member or member's representative must retain authority and responsibility for consumer direction.

46. Sections 2.9.6.10.7 through 2.9.10.6.13 shall be deleted and replaced as follows:

2.9.6.10.7 For members electing to participate in consumer direction, the member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs. The care coordinator shall assist the member in implementing the back-up plan as needed, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.

2.9.6.10.8 For members electing to participate in consumer direction, the member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis or as frequently as needed, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in consumer- directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

2.9.6.10.9 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, shall be signed by the member (or the member's representative, as applicable) and the care coordinator. The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

2.9.6.10.10 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that, for members participating in consumer direction, the FEA is invited to participate in these meetings as appropriate.

2.9.6.10.11 Within three (3) business days of updating the member's plan of care (see Section 2.9.6.6.2.8.1), the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the FEA (see Section 2.9.6.6.2.8.1. of this Agreement).

2.9.6.10.12 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for consumer directed services shall include authorized service, authorized units of service, including amount, frequency and duration and the schedule at which services are needed, start and end dates, and service code(s).

2.9.6.10.13 The member's care coordinator/care coordination team shall work with and coordinate with the FEA in implementing consumer direction of eligible CHOICES HCBS (see Section 2.9.7.3.4).

47. Section 2.9.6.10 shall be amended by adding a new Section 2.9.6.10.14 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.10.14 The member's care coordinator shall monitor consumer direction of eligible CHOICES HCBS.

48. The renumbered Section 2.9.6.10.17 shall be deleted and replaced as follows:

2.9.6.10.17 If at any time abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with assistance from the FEA as appropriate, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and shall provide, at least annually, education of the member and his/her representative of the risk of, and signs and symptoms of, abuse and neglect. The CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

49. Section 2.9.6.11.18.1 shall be deleted and replaced as follows:

2.9.6.11.18.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

50. Section 2.9.6.12.7 shall be deleted and replaced as follows:

2.9.6.12.7 Notwithstanding the address and/or phone number in the 834 file, the CONTRACTOR shall use the member's address or phone number or appropriate alternative phone number, as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5.) for all HCBS that will be logged into the EVV system.

51. Section 2.9.7.1.1 shall be amended by adding the phrase "in Group 2" to the second sentence as follows:

2.9.7.1.1 The CONTRACTOR shall offer consumer direction of eligible CHOICES HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons in Group 2 electing consumer direction of eligible CHOICES HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction or that is not a CHOICES HCBS shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible CHOICES HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of eligible CHOICES HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of eligible CHOICES HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible CHOICES HCBS or to withdraw from participation in consumer direction of eligible CHOICES HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of eligible CHOICES HCBS.

52. The title of Section 2.9.7.2 shall be amended to say "Representative for Consumer Direction".

53. Section 2.9.7.2.6 shall be deleted and replaced as follows:

2.9.7.2.6 A member may change his/her representative at any time. The member shall immediately notify his/her care coordinator and the FEA when he/she intends to change representatives. The care coordinator shall verify that the new representative meets the qualifications as described above. A new representative agreement shall be completed and signed, in the presence of a care coordinator, prior to the new representative assuming their respective responsibilities. The care coordinator shall immediately notify the FEA in writing when a member changes his/her representative and provide a copy of the representative agreement. The CONTRACTOR shall facilitate a seamless transition to the new representative, and ensure that there are no interruptions or gaps in services. As part of the needs assessment and plan of care process, the care coordinator shall educate the member about the importance of notifying the care coordinator prior to changing a representative.

54. Sections 2.9.7.3.2.1 and 2.9.7.3.2.2 shall be deleted and replaced as follows:

2.9.7.3.2.1 Assign a supports broker to each CHOICES member electing to participate in consumer direction of eligible CHOICES HCBS. The supports broker shall be responsible for assisting the member with enrollment into consumer direction and with the enrollment of new workers;

2.9.7.3.2.2 Notify the member's care coordinator upon becoming aware of any additional risk associated with the member participating in consumer direction that may need to be addressed in the risk assessment and plan of care processes;

55. Sections 2.9.7.3.2.9 shall be deleted and replaced as follows:

2.9.7.3.2.9 Develop and implement a process to support members or their representatives in ensuring that consumer directed workers maintain in the member's home (or alternative location or format approved by TENNCARE) documentation of service delivery to support payments for services provided through consume direction, and periodically monitor such documentation;

56. Section 2.9.7.3.2.12 shall be amended by adding the word "and" to the end of the paragraph, the existing Section 2.9.7.3.2.13 shall be deleted in its entirety and the renumbered Section 2.9.7.3.2.13 shall be deleted and replaced as follows. All references shall be updated accordingly.

2.9.7.3.2.13 Notify the CONTRACTOR within no more than twenty-four (24) hours of identification of critical incidents (see Section 2.15.7).

57. Section 2.9.7.3.3.1 through 2.9.7.3.3.6 shall be deleted and replaced as follows:

2.9.7.3.3.1 As needed, assist the member and/or representative in developing job descriptions;

2.9.7.3.3.2 As needed, assist the member and/or representative in locating and recruiting workers;

2.9.7.3.3.3 As needed, assist the member and/or representative in interviewing workers (developing questions, evaluating responses);

2.9.7.3.3.4 Assist the member and/or representative in developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care;

2.9.7.3.3.5 Assist the member and/or representative in managing and monitoring payments to workers; and

2.9.7.3.3.6 Assist the member/representative in identification and training of new workers, as needed.

58. Section 2.9.7.3.4 shall be deleted and replaced as follows:

2.9.7.3.4 The CONTRACTOR's care coordination functions shall not duplicate the supports brokerage functions performed by the FEA or its subcontractor. A member's care coordinator shall be responsible for monitoring the member's services through consumer direction.

59. Section 2.9.7.4.5 and 2.9.7.4.7 shall be deleted and replaced as follows:

2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of eligible CHOICES HCBS, based upon the results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member's file and provide a copy to the FEA.

2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each by type; and care coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of eligible CHOICES HCBS, the signed POC, and the representative agreement, if applicable. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.

60. Sections 2.9.7.4.10.1, 2.9.7.4.10.4, 2.9.7.4.10.6, 2.9.7.4.10.7, 2.9.7.4.10.10. 2.9.7.4.10.11, and 2.9.7.4.10.13 shall be deleted and replaced as follows:

2.9.7.4.10.1 The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA shall assist the member/representative as needed in developing and verifying the initial back-up plan for consumer direction that adequately identifies how the member/representative will address situations when a scheduled worker is not available or fails to show up as scheduled. The care coordinator shall assist the member as needed with implementing the back-up plan and shall update and verify the back-up plan annually and as needed.

2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. For the initial back-up plan, the FEA shall confirm with these persons and/or organizations their willingness and availability to provide care when needed, document confirmation in the member's file and forward a copy of the documentation to the CONTRACTOR. The care coordinator shall be responsible for updating and verifying the back-up plan on an ongoing basis.

2.9.7.4.10.6 The care coordinator shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to meet the member's needs, and immediately address any concerns with the back-up plan or the member's care.

2.9.7.4.10.7 The care coordinator shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the care coordinator shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the FEA.

2.9.7.4.10.10 The care coordinator shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risks, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement shall be signed by the member or his/her representative (as applicable) and by the care coordinator. The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file.

2.9.7.4.10.11 The FEA shall notify the member's care coordinator immediately if they become aware of changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk, or changes to the plan of care or risk agreement.

2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the FEA is invited to participate in these meetings as appropriate.

61. Sections 2.9.7.5.5 and 2.9.7.5.8 shall be deleted and replaced as follows:

2.9.7.5.5 On a weekly basis the FEA shall update the member's care coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall assist the member or his/her representative as needed in implementing the member's back-up plan for consumer direction.

62. Section 2.9.7.6.1.1 shall be deleted and replaced as follows:

2.9.7.6.1.1 A member cannot waive a background check for a potential worker. A background check may reveal a potential worker's past criminal conduct that may pose an unacceptable risk to the member. The following findings may place the member at risk and may result in a potential worker failing the background check, possibly disqualifying a person from serving as a worker:

63. Section 2.9.7.6.1.2 through 2.9.7.6.1.2.5 shall be deleted and replaced and Section 2.9.7.6.1 shall be amended by adding a new Sections 2.9.7.6.1.3, and 2.9.7.6.1.4 and 2.9.7.6.1.4.1 as follows:

2.9.7.6.1.2 If a potential worker fails the background check, the potential worker may request an individualized assessment that will be conducted by the member with the help of the FEA. The individualized assessment process will help determine whether the potential worker may be excluded because of past criminal conduct. The individualized assessment will provide the potential worker with notice that he/she has been screened out because of criminal conduct and provide an opportunity for the potential worker to explain why the exclusion should not be applied to his/her circumstances. The member, with the assistance of the FEA will consider the following factors:

2.9.7.6.1.2.1 Whether or not the evidence gathered during the potential worker's individualized assessment shows that the criminal conduct is related to the job in such a way that could place the member at-risk;

2.9.7.6.1.2.2 The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or the manufacture, sale or distribution of drugs; and

2.9.7.6.1.2.3 The time that has passed since the offense or conduct and/or completion of the sentence.

2.9.7.6.1.3 After considering the individualized assessment and any other evidence submitted by the potential worker, the member can decide not to hire the potential worker or may request from TENNCARE an exception to the potential worker's possible disqualification.

2.9.7.6.1.4 If a member decides to request an exception to the possible disqualification of the potential worker, the FEA shall assist the member in completing the exception request Form and submitting the potential worker's individualized assessment to TENNCARE. TENNCARE shall review the exception request and determine whether or not the potential worker's possible exclusion from employment would be job related and consistent with business necessity (i.e. the exclusion effectively links specific criminal conduct and its dangers with the risks inherent in the duties of a particular position), the nature and gravity of the criminal conduct, and the time that has passed since the criminal conduct and or the completion of the sentence, and that applicable federal and state laws do not prohibit the hiring of persons convicted of the criminal conduct in question.

2.9.7.6.1.4.1 TENNCARE approved exceptions to a potential worker's disqualification shall only be effective for a maximum of one (1) year from the approval date and may be revoked if the member is at-risk. The member is responsible for requesting a renewal of the worker's exception to disqualification and the FEA shall assist the member with that request. Renewals shall follow the exception to disqualification process outlined in Section 2.9.7.6.1.4.

64. Section 2.9.7.7.2 shall be amended by adding a new Section 2.9.7.7.2.9 as follows:

2.9.7.7.2.9 Ensuring workers maintain daily communication notes for authorized services provided.

65. Section 2.9.7.7.4.4 shall be deleted and replaced as follows:

2.9.7.7.4.4 Fraud and abuse identification and reporting;

66. Section 2.9.7.7.4.7 shall be amended by deleting the word "and" from the end of the paragraph, Section 2.9.7.7.4.8 shall be deleted and replaced, and Section 2.9.7.7.4 shall be amended by adding a new Section 2.9.7.7.4.9 as follows:

2.9.7.7.4.8 As appropriate, administration of self-directed health care task(s). The member or his/her representative shall be responsible for training the worker(s) regarding individualized service needs and preferences and for specific training regarding health care tasks the member or his/her representative elects to self-direct (as applicable); and

2.9.7.7.4.9 Universal precautions and blood borne pathogens training.

67. Section 2.9.7.7.7 shall be deleted and replaced as follows:

2.9.7.7.7 The FEA shall be responsible for verifying and validating the worker's completion of required CPR and First Aid training from an approved provider prior to initiation of services and payment for services. Ongoing, the FEA shall ensure that workers maintain CPR and first aid certification and receive required refresher training as a condition of continued employment. The FEA may assist workers in locating appropriate courses for initial certification and recertification as appropriate. Additional training components may be provided to a worker to address issues identified by the FEA, care coordinator, member and/or the representative or at the request of the worker.

68. Section 2.9.7.8.4 and 2.9.7.8.5 shall be deleted and replaced as follows:

2.9.7.8.4 The CONTRACTOR shall monitor implementation of the back-up plan by the member or his/her representative.

2.9.7.8.5 The CONTRACTOR shall monitor a member's participation in consumer direction of eligible CHOICES HCBS to determine, at a minimum, the success and the viability of the service delivery model for the member. The CONTRACTOR shall note any patterns, such as frequent turnover of representatives or workers, habitual late and/or missed visits by workers, unauthorized schedule changes, failure to cooperate with the FEA and changing between consumer direction of eligible CHOICES HCBS and contract providers that may warrant intervention by the CONTRACTOR. The CONTRACTOR may submit a request to TENNCARE, pursuant to TennCare policy, to involuntarily withdraw the member from consumer direction of eligible CHOICES HCBS if the CONTRACTOR has concerns about its ability to protect the health, safety and welfare of the member (see Section 2.9.7.9.4). The FEA may submit a request to the CONTRACTOR to involuntarily withdraw the member from consumer direction of eligible CHOICES HCBS due to concerns regarding the member's health, safety and welfare if the member continues in consumer direction. The

CONTRACTOR must submit copies of all such requests to TENNCARE with documentation of its decision.

69. Section 2.9.8.4.5 shall be amended by deleting the reference "(see 2.9.6.9.2.1.16)" and replacing it with (See Section 2.9.6.9.2.1.17)".

70. Section 2.9.8.8.4 shall be deleted and replaced as follows:

2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 to CHOICES Group 1. A transition from Group 2 to Group 1will not necessitate a member's disenrollment from MFP, regardless of the length of stay in the facility, except in cases that care coordinator has assessed the reason for the re-institutionalization and determined that the member is not an appropriate candidate for continued enrollment in CHOICES Group 2 and MFP.

71. Section 2.9.8.5.2 shall be amended by adding the word "no" as follows:

2.9.8.5.2 Upon conclusion of the member's 365-day participation period in MFP, the Plan of Care shall be updated to reflect that he is no longer participating in MFP.

72. The opening paragraph of Section 2.9.12.2 shall be deleted and replaced as follows:

2.9.12.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM and/or the ID HCBS waiver contractor for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

73. Section 2.9.12.3 shall be deleted and replaced as follows:

2.9.12.3 Operating Principles

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

74. Section 2.9.15.3 shall be amended by adding a new Section 2.9.15.3.1 which shall read as follows:

2.9.15.3.1 If a member receiving home health or private duty nursing services will be subject to a reduction in covered services provided by the CONTRACTOR upon turning twenty-one (21) years of age and the member also receives HCBS Waiver services from DIDD, the CONTRACTOR, DIDD, and the Independent Support Coordinator (ISC) as applicable shall, pursuant to policies and processes established by TENNCARE, coordinate benefits to implement any changes in HCBS Waiver Services at the same time that MCO services are reduced to ensure as seamless a transition as possible.

75. Section 2.11.8 shall be amended by adding a new Section 2.11.8.1.3 as follows and renumbering the existing Section accordingly, including any references thereto.

2.11.8.1.3 To the extent the CONTRACTOR has delegated credentialing agreements in place with any approved delegated credentialing agency, the CONTRACTOR shall ensure all providers submitted to the CONTRACTOR from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

76. Section 2.11.8.4.1.2.4 shall be amended by adding a new Section 2.11.8.4.1.2.4.1 as follows:

2.11.8.4.1.2.4.1 Has a policy and process in place to address exception requests for workers who fail a criminal background check (see Section 2.9.7.6);

77. Section 2.12.4 shall be deleted in its entirety and the existing Section 2.12.10 shall be deleted and replaced by a new Section 2.12.8 as follows, the remaining Sections shall be renumbered accordingly including any references thereto.

2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in Section 2.12.9 below.

78. Section 2.12.9.66.1 shall be deleted and replaced as follows:

2.12.9.66.1 Language that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section 2.3.5, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the CONTRACTOR or in the employment practices of the provider.

79. The renumbered Section 2.12.10.10 shall be deleted and replaced as follows:

2.12.10.10 Require the nursing facility to comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including ensuring that a level I screening has been completed prior to admission, a level II evaluation has been completed prior to admission when indicated by the level I screening, and a review is completed based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from specialized services. The facility shall collaborate with the CONTRACTOR and with other providers as needed to help ensure that current information regarding the member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination.

80. Section 2.13.1.8 shall be deleted and replaced by new Sections 2.13.1.8 and 2.13.1.9 as follows:

2.13.1.8 The CONTRACTOR agrees to implement retrospective episode based reimbursement and PCMH strategies consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes:

2.13.1.8.1 Using a the retrospective administrative process that is aligned with the model designed by TENNCARE;

2.13.1.8.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode and definition of quality measures;

2.13.1.8.3 Delivering performance reports with same appearance and content as those designed by the state / payer coalition;

2.13.1.8.4 Implementation at a pace dictated by the State, likely 3-5 new episodes per quarter with appropriate lead time to allow payers and provider contracting;

2.13.1.8.5 Participate in a State-led process to design and launch new episodes, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee.

2.13.1.9 The CONTRACTOR shall implement State Budget Reductions and Payment Reform Initiatives, including retrospective episode based reimbursement, as described by TENNCARE. The CONTRACTOR's failure to implement State Budget Reductions and/or Payment Reform Initiatives as described by TENNCARE may, at the discretion of TENNCARE, result in the CONTRACTOR forfeiting savings that would have been realized based on the timely implementation, including the forfeiture of recoupment from providers.

81. Section 2.13.3.3 shall be deleted and replaced as follows:

2.13.3.3 If, prior to the end date specified by TENNCARE in its approval of Level II reimbursement for nursing facility services, the CONTRACTOR determines that the member no longer needs and/or the nursing facility is no longer providing the skilled and/or rehabilitative services for which Level II reimbursement of nursing facility services was approved by TENNCARE, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of reimbursement for nursing facility services. The

CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility at the Level I (rather than Level II) per diem rate only when such rate is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement or upon approval from TENNCARE of a reduction in the member's level of care (i.e., reimbursement) as reflected on the outbound 834 enrollment file.

82. Section 2.14.1.15.1 shall be deleted and replaced as follows:

2.14.1.15.1 The CONTRACTOR shall ensure that level II reimbursement of nursing facility care is provided for CHOICES members who have been determined by TENNCARE to be eligible for Level II reimbursement of nursing facility care for the period specified by TENNCARE, except when level I reimbursement is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement. The CONTRACTOR shall monitor the member's condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires and/or the facility is no longer providing the skilled and/or rehabilitative services for which Level II reimbursement of nursing facility care was approved by TENNCARE, the CONTRACTOR may submit to TENNCARE a request to modify the member's level of reimbursement for nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility at the Level I (rather than Level II) per diem rate only when such rate is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement or upon approval from TENNCARE of a reduction in the member's level of care (i.e., reimbursement) as reflected on the outbound 834 enrollment file.

83. Section 2.14.5.2 and Section 2.14.5.5 shall be deleted and replaced as follows:

2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such lesser rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.

2.14.5.5 The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the plan of care, including the schedule at which services are needed and any updates to the plan of care and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

84. Sections 2.15.3.1 through 2.15.3.2.6 shall be deleted and replaced as follows:

2.15.3.1 The CONTRACTOR shall perform at least two (2) clinical and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.

2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one (1) in the area of either child health or perinatal (prenatal/postpartum) health.

2.15.3.1.2 One (1) of the three (3) non-clinical PIPs shall be in the area of long-term care. The CHOICES special study may not be used as a PIP. The CONTRACTOR shall use existing processes, methodologies, and protocols, including the CMS protocols.

2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.

85. Section 2.15.6.2 shall be deleted and replaced as follows:

2.15.6.2 Annually, beginning in 2009, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by NCQA. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. The survey results shall be reported separately for each Grand Region in which the CONTRACTOR operates. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

86. Section 2.15.7.1.4.3, 2.15.7.1.4.6, and 2.15.7.1.4.7 shall be deleted and replaced as follows:

2.15.7.1.4.3 Requiring that its staff and contract CHOICES HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members. If the allegation is in reference to a CHOICES HCBS worker, the worker shall be immediately released from providing services to any TennCare member until the investigation is complete.

2.15.7.1.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in a accordance with Section 2.15.7.1.4.1, and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section 2.9.7.8.6); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding

critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.7.1.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.15.7.1.4.7 Reviewing any FEA reports regarding critical incidents and investigate, as appropriate to determine any necessary corrective actions needed by the member and/or his/her representative to help ensure the member's health and safety.

87. Section 2.15.7 shall be amended by adding a new Section 2.15.7.3 and renumbering the remaining Section accordingly, including any references thereto.

2.15.7.3 Home Health Agency Critical Incident Reporting

2.15.7.3.1 The CONTRACTOR shall identify and track all significant Home Health Agency (HHA) critical incidents involving non-CHOICES enrollees. A HHA critical incident shall include those significant incidents that are reported to the CONTRACTOR from the HHA including unexpected death, major/severe injury, safety issues, or suspected physical, mental or sexual abuse or neglect. Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of the CONTRACTOR receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident.

88. Section 2.17.4.7.27 shall be amended by deleting the phrase ", and DHS".

89. Section 2.17.5.3.5 shall be deleted and replaced as follows:

2.17.5.3.5 A notice of the right to file a discrimination complaint, as provided for by applicable federal and state civil rights laws, including, but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990 that includes a phone number for assistance and a website link to the complaint form. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;

90. Section 2.18.10.2 shall be deleted and replaced as follows:

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

91. Section 2.19.3.18 shall be deleted and replaced as follows:

2.19.3.18 Member TennCare eligibility and eligibility-related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TENNCARE.

92. Section 2.20.1.8 shall be amended by deleting the word "repayment" and replacing it with the phrase "recoupment or withhold" as follows:

2.20.1.8 This prohibition described above in Section 2.20.1.7 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The CONTRACTOR shall check with the Bureau of TennCare, Program Integrity Unit before initiating any recoupment or withhold of any program integrity related funds (See Section 2.20.1.7) to ensure that the recoupment or withhold is permissible. In the event that the CONTRACTOR obtains funds in cases where recoupment or withhold is prohibited under this section, the CONTRACTOR will return the funds to the provider.

93. Section 2.20.2.11 shall be amended by adding a new sentence as follows:

2.20.2.11 The CONTRACTOR, subcontractor 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. Such records will be made available at no cost to the requesting agency. 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, subcontractor 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.

94. Section 2.22.5 shall be amended by adding a new Section 2.22.5.4 as follows:

2.22.5.4 The CONTRACTOR shall monitor, on an at least a monthly basis, the number of each long-term care provider's denied claims for long-term care services (NF and CHOICES HCBS), and shall initiate training and technical assistance as needed to any long-term care provider whose monthly volume of denied claims for long-term care services exceeds twenty percent (20%). The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a report of all long-term care contractors for whom the number of denied claims for long-term care services exceeded twenty percent (20%) of the total number of claims for long-term care services submitted during any month, the total number and percent of denied claims for long-term care services for that month, the total dollar value of denied claims for long-term care services, the type of intervention (e.g., training or technical assistance) determined to be needed and provided by the CONTRACTOR, and the current status of such denied claims (e.g., resubmitted, pending action by the provider, determined to be duplicate claims, etc.).

95. Section 2.24.4.3 shall be deleted and replaced as follows:

2.24.4.3 The CONTRACTOR's abuse and neglect plan shall also define the role and responsibilities of the FEA and supports broker (see definition in Section 1) in assessing and reducing a member's risk of abuse and neglect, identifying and reporting abuse and neglect, protecting a member if abuse and/or neglect is suspected; training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding the protocols identified in Sections 2.24.4.2.1 through 2.24.4.2.6 above; and training members and caregivers regarding identification and reporting of suspected abuse and/or neglect. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.24.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

96. Sections 2.27.5.14, 2.27.5.20 and 2.27.5.24 shall be deleted and replaced as follows:

2.27.5.14 Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint, and breach notification;

2.27.5.20 Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased for fifty (50) years following the date of an enrollee's death, effective September 23, 2013;

2.27.5.24 Obtain a third (3rd) party certification of their HIPAA standard transaction compliance ninety (90) calendar days before the start date of operations, if applicable, and upon request by TENNCARE.

97. Section 2.27.9.4.7 shall be deleted and replaced as follows:

2.27.9.4.7 If a court issues a subpoena for a case record or for any CONTRACTOR representative to testify concerning an applicant or beneficiary, the CONTRACTOR must notify the State at least ten (10) days prior to the required production date so the State may work with the CONTRACTOR regarding CONTRACTOR's informing the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014; and

98. Sections 2.27.10.11.2, 2.27.10.11.3, and 2.27.10.11.4 shall be deleted and replaced as follows:

2.27.10.11.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19) – "Protected health information" or "PHI" means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

2.27.10.11.3 "Personally Identifiable information" or "PII" refers to any information about an individual maintained by an agency, including, but not limited to, education, financial

transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is lined or linable to a specific individual, such as date and place of birth, mother's maiden name, etc.

2.27.10.11.4 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

99. Sections 2.27shall be amended by adding new Sections 2.27.11 through 2.27.13 as follows:

2.27.11 Sensitive Data Related to Alcohol and Drug Abuse Enrollee Records for Substance Abuse Treatment.

2.27.11.1 This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

2.27.11.2 A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 C.F.R. § 2.32 (SAMHSA)

2.27.12 Federal Tax Information (FTI).

2.27.12.1 Any FTI made available shall be used only for the purpose of carrying out the provisions of this Agreement.

2.27.12.2 Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer of employer of the Grantee is strictly prohibited.

2.27.13 Failure to comply with federal regulations regarding HIPAA/HITECH, SSA, Medicaid, CHIP, SAMHSA, and FTI data may result in criminal and civil fines and penalties.

100. Sections 2.28.3, 2.28.6.2, and 2.28.7 shall be deleted and replaced as follows:

2.28.3 The CONTRACTOR's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of language assistance services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section 2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.

2.28.6.2 Discrimination Complaints against the CONTRACTOR's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, provider's employees and/or subcontractors related to the provision of and/or access to TennCare covered services be reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall inform TENNCARE of such complaints within two (2) business days from the date CONTRACTOR learns of such complaints. If TENNCARE requests that the CONTRACTOR'S nondiscrimination compliance officer assist TENNCARE with conducting the initial investigation, the CONTRACTOR'S nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. Once an initial investigation has been completed, the CONTRACTOR's nondiscrimination compliance officer shall report his/her determinations to TENNCARE. At a minimum, the CONTRACTOR's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. TENNCARE reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, and subcontractors.

2.28.7 The CONTRACTOR shall use and have available to TennCare enrollees, TennCare's Discrimination complaint form located on TennCare's website under the nondiscrimination link at http://www.tn.gov/tenncare/members.shtml. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages. When requests for assistance to file a discrimination complaint are made by enrollees, the CONTRACTOR shall assist the enrollees with submitting complaints to TENNCARE. In addition, the CONTRACTOR shall inform its employees, providers, and subcontractors how to assist TENNCARE enrollees with obtaining discrimination complaint forms and assistance from the CONTRACTOR with submitting the forms to TENNCARE and the CONTRACTOR.

101. Section2.29.1.3 shall be amended by adding a new Section 2.29.1.3.19 as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.29.1.3.19 A staff person to serve as the Litigation Hold Contact. This individual shall be responsible for responding to all litigation hold requests from TENNCARE;

102. Section 2.30.1 shall be amended by adding a new Section 2.30.1.8 which shall read as follows:

2.30.1.8 In accordance with the requirements set forth in 42 U.S.C. § 300kk, the CONTRACTOR must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants and members and from applicants' and members' parents or legal guardians if applicants or members are minors or legally incapacitated individuals. In collecting this data the CONTRACTOR shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Race and Ethnic Standards established for *Federal Statistics and Administrative Reporting* include the following categories as defined by the OMB:

2.30.1.8.1 Race – American Indian or Alaska Native, Asian, black or African American, native Hawaiian or other Pacific Islander, white;

2.30.1.8.2 Ethnicity – Hispanic or Latino, Not Hispanic or Latino.

103. Section 2.30.5 through 2.30.5.3 shall be deleted and replaced as follows:

2.30.5 Population Health Reports

2.30.5.1 The CONTRACTOR shall submit a quarterly *Population Health Update Report* addressing all seven (7) Population Health Programs (see Section 2.8.4 of this Agreement). The report shall include process and operational data and any pertinent narrative to include any staffing changes, training or new initiatives occurring in the reporting period.

2.30.5.2 The CONTRACTOR shall submit a quarterly *Population Health Stratification Data Report*, through the current secure system, which shall include a list in Comma Separated Value (CSV) format consisting of the name, ID, DOB, stratification or all risk levels and the corresponding dates of eligibility for the level and program assignments for all of the CONTRACTOR's members (see Section 2.8.11.5).

2.30.5.3 The CONTRACTOR shall submit annually, on December 1 after the close of the state fiscal year, a *Population Health Annual Report* in the format described in the annual report template provided by TENNCARE. The report shall include active participation rates, as designated by NCQA, for programs with active interventions. Short term and intermediate outcome data reporting is required. Member satisfaction shall be reported based upon NCQA requirements along with functional status for members in the Chronic Care Management and Complex Case Management programs.

2.30.5.4 The CONTRACTOR shall submit annually on March 30, a *Population Health Program Description* following the guidance provided by TENNCARE addressing Section 2.8 of this Agreement. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk Level. The program description shall also include a CHOICES narrative as outlined in Section 2.8.11 of this Agreement and address the Clinical Practice Guidelines reference in Section 2.8.6 of this Agreement.

104. Sections 2.30.6.1 and 2.30.6.1.1 shall be deleted in its entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

105. Section 2.30.6 shall be amended by adding a new Section 2.30.6.4 as follows and renumbering the remaining Sections accordingly.

2.30.6.4 The CONTRACTOR shall submit a monthly *Nursing Facility Short-Term Stay Report* in a format specified by TENNCARE that includes but it not limited to, for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions

the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

106. Section 2.30.12 shall be amended by adding back Section 2.30.12.9 as follows which was previously deleted in error.

2.30.12.9 The CONTRACTOR shall submit a quarterly Behavioral Health Adverse Occurrences Report in accordance with Section 2.15.7.2 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.9.1 The number of adverse occurrences, overall and by:

2.30.12.9.1.1 Date of occurrence

2.30.12.9.1.2 Type of adverse occurrence;

2.30.12.9.1.3 Location;

2.30.12.9.1.4 Provider name; and

2.30.12.9.1.5 Action Taken by Facility/Provider.

107. Section 2.30.17 shall be amended by adding a new Section 2.30.17.6 as follows:

2.30.17.6 The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a Denied Claims Report on all long-term care contractors (NF and HCBS) for whom the number of denied claims for long-term care services exceeded twenty percent (20%) of the total number of claims for long-term care services submitted during any month. The report shall include the name and provider number of the long-term care contractor, the total number and percent of denied claims for long-term care services for that month, the total dollar value of denied claims for long-term care services, the type of intervention (e.g., training or technical assistance) determined to be needed and provided by the CONTRACTOR, and the current status of such denied claims (e.g., resubmitted, pending action by the provider, determined to be duplicate claims, etc.).

108. Section 3.4.8 shall be deleted and replaced as follows:

3.4.8 In the event the amount of the five and one half percent (5.5%) premium tax is increased or decreased during the term of this Agreement, the payments shall be increased or decreased by an amount equal to the increase/decrease in premium payable by the CONTRACTOR.

109. Section 3.16.1.1 shall be deleted and replaced as follows:

3.16.1.1. In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed six billion, eight hundred eight million, one hundred seventy thousand, one hundred twenty nine dollars ($6,808,170,129.00).

110. Section 4.4.8.2.12 shall be deleted and replaced as follows:

4.4.8.2.12 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement. Required reporting shall include, but not be limited to any necessary data and/or reporting required to comply with the Medicaid Payment for Primary Care as required in Section 2.13.8 of this Agreement;

111. Section 4.20.2.2.7 shall be amended by adding new PROGRAM ISSUES, LEVELs A.33 and A.34 as follows:

A.33	Failure to ensure that a member utilizing the short-term stay benefit is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members (see Section 2.6.1.5.3.1)		$500 per day, per occurrence for each calendar day that a member exceeds the ninety (90) day benefit limit in accordance with this agreement. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement
A.34	Failure to complete and submit to TENNCARE at least eight (8) business days prior to expiration of a member's current LOC eligibility segment, a new LOC assessment, including all required supporting documentation needed to appropriately determine the member's LOC eligibility going forward (see Section 2.9.6.9.3.1.2)		$500 per day, per occurrence for each calendar day beyond eight (8) business days prior to expiration of the member's current LOC eligibility segment. These amounts shall be multiplied by two (2) when the CONTRACTROR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

112. Section 4.32.1 shall be deleted and replaced as follows:

4.32.1 No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section 2.3.6 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the CONTRACTOR.

113. Mental Health Case Management Services in Attachment I shall be amended by deleting and replacing the paragraphs labeled "Level 2a and Level 2b" as follows:

Level 2a and Level 2b

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

Where available, peer recovery services and family support services may be used as an adjunct to the case manager in monitoring the member prior to discharge from Level 2 case management. However, at no time should peer recovery services and family support services in the form of Certified Peer Recovery Specialist and/or Certified Family Support Specialists, or any other form, become a substitute for case managers in the delivery of case management services.

114. Psychiatric Rehabilitation Services in Attachment I shall be amended by deleting and replacing the paragraphs labeled "Peer Support" and adding new paragraphs labeled Family Support Services as follows:

Peer Recovery Services

Peer recovery services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and are Certified Peer Recovery Specialists. A Certified Peer Recovery Specialist is a person who has identified himself or herself as having received or is receiving mental health, substance abuse or co-occurring disorder services in his or her personal recovery process, has undergone training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist peers with the recovery process and received certification.

These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Family Support Services

Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by persons who are a Certified Family Support Specialist. A Certified Family Support Specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed training recognized by TDMHSAS on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery.

These services include assisting caregivers in managing their child's illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

115. The Definition under Crisis Services in Attachment I shall be deleted and replaced as follows:

Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified Peer Recovery Specialists and/or Certified Family Support Specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center
- If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis
- For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.

116. 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 Rural: 30 miles

  (b) Distance Urban: 20 miles

  (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 distance will be the usual and customary, not to exceed 30 miles, except in rural areas where access distance 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.

- 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 distance will be the usual and customary, not to exceed 30 miles, 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.

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

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

117. Attachment V shall be deleted and replaced as follows:

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Amendment 16 (cont.)

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members ---------- Travel distance does not exceed 60 miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members ---------- The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **CHILD** members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management	Not subject to geographic access standards	Within 10 business days

& Recovery, Peer Recovery services or Family Support service		
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1

Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Recovery Services	88
Family Support Services	49
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41

118. Attachment VIII shall be amended by deleting and replacing Items 113 and 114 with new Items 113, 114 and 115, adding a new Item 119 and by deleting and replacing the renumbered Items 179 through 181 with new Items 179 through 183 as follows:

113. Population Health Stratification Data Report (see Section 2.30.5.2)

114. Population Health Annual Report (see Section 2.30.5.3)

115. Population Health Program Description (see Section 2.30.5.4)

119. Monthly Nursing Facility Short-Term Stay Report (see Section 2.30.6.4)

179. Monthly Focused Claims Testing Report (see Section 2.30.17.2)

180. EOB Report (see Section 2.30.17.3)

181. Claims Activity Report (see Section 2.30.17.4)

182. CHOICES Cost Effective Alternatives Report (see Section 2.30.17.5)

183. Quarterly Denied Claims Report (See Section 2.30.17.6)

119. Exhibit B of Attachment IX shall be amended by deleting the word "Peer Support" and replacing it with "Peer Recovery Services and Family Support Services".

120. Attachment XII shall be amended by adding new Exhibits I, J and K as follows:

EXHIBIT I
CAPITATION RATES – Annual Risk Adjusted
MIDDLE
UnitedHealthcare
EFFECTIVE July 1, 2012

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 583.37
	Age 1 - 13	$ 102.84
	Age 14 - 20 Female	$ 234.12
	Age 14 - 20 Male	$ 147.86
	Age 21 - 44 Female	$ 390.38
	Age 21 - 44 Male	$ 254.73
	Age 45 – 64	$ 429.78
	Age 65 +	$ 446.59
Uninsured/Uninsurable	Age Under 1	$ 583.37
	Age 1 - 13	$ 92.59
	Age 14 - 19 Female	$ 148.70
	Age 14 – 19 Male	$ 135.60
Disabled	Age < 21	$ 2,225.76
	Age 21 +	$ 1,038.01
Duals/Waiver Duals	All Ages	$ 224.17
CHOICES Rate	CHOICES 1 Duals	$ 3,741.80
	CHOICES 2 Duals	$ 3,741.80
	CHOICES 3 Duals	$ 1,442.03
	CHOICES 1 Non-Duals	$ 5,641.80
	CHOICES 2 Non-Duals	$ 5,641.80
	CHOICES 3 Non-Duals	$ 4,167.38

EXHIBIT J
CAPITATION RATES includes
One Time Adjustment CHOICES Acuity Based Funding
MIDDLE
UnitedHealthcare
EFFECTIVE July 1, 2012

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 583.37
	Age 1 - 13	$ 102.84
	Age 14 - 20 Female	$ 234.12
	Age 14 - 20 Male	$ 147.86
	Age 21 - 44 Female	$ 390.38
	Age 21 - 44 Male	$ 254.73
	Age 45 – 64	$ 429.78
	Age 65 +	$ 446.59
Uninsured/Uninsurable	Age Under 1	$ 583.37
	Age 1 - 13	$ 92.59
	Age 14 - 19 Female	$ 148.70
	Age 14 – 19 Male	$ 135.60
Disabled	Age < 21	$ 2,225.76
	Age 21 +	$ 1.038.01
Duals/Waiver Duals	All Ages	$ 224.17
CHOICES Rate	CHOICES 1 Duals	$ 3,820.56
	CHOICES 2 Duals	$ 3,820.56
	CHOICES 3 Duals	$ 1,442.03
	CHOICES 1 Non-Duals	$ 5,717.69
	CHOICES 2 Non-Duals	$ 5,717.69
	CHOICES 3 Non-Duals	$ 4,167.38

EXHIBIT K
CAPITATION RATES - PCP Rate Bump Adjustment
MIDDLE
UnitedHealthcare
EFFECTIVE January 1, 2013

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 615.92
	Age 1 - 13	$ 110.99
	Age 14 - 20 Female	$ 241.53
	Age 14 - 20 Male	$ 152.69
	Age 21 - 44 Female	$ 402.75
	Age 21 - 44 Male	$ 264.17
	Age 45 – 64	$ 446.81
	Age 65 +	$ 459.08
Uninsured/Uninsurable	Age Under 1	$ 615.92
	Age 1 - 13	$ 100.53
	Age 14 - 19 Female	$ 156.26
	Age 14 – 19 Male	$ 141.10
Disabled	Age < 21	$ 2,240.64
	Age 21 +	$ 1.062.33
Duals/Waiver Duals	All Ages	$ 224.17
CHOICES Rate	CHOICES 1 Duals	$ 3,820.56
	CHOICES 2 Duals	$ 3,820.56
	CHOICES 3 Duals	$ 1,442.03
	CHOICES 1 Non-Duals	$ 5,770.38
	CHOICES 2 Non-Duals	$ 5,770.38
	CHOICES 3 Non-Duals	$ 4,228.68

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, 2014.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Agreement, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
Larry B. Martin
Commissioner

DATE: _____

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

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

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
Brian Kelsey, Ken Yager
Steve Southerland
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Mark White, Vice-Chairman
Representatives
Charles Curtiss, Pat Marsh
Jeremy Faison, Mark Pody
Brenda Gilmore, David Shepard
Matthew Hill, Tim Wirgau
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

TO: Jessica Robertson, Chief Procurement Officer
Department of General Services

FROM: Senator Bill Ketron, Chairman BK
Representative Mark White, Vice-Chairman MW

DATE: April 22, 2013

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 4/22/13)

RFS# 318.66-051 (Edison # 29634)
Department: Finance and Administration
Division: Health Care Finance and Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment contains several language updates including the CHOICES Plan of Care, benchmarks, and pharmacy costs; and adds ADA requirements.
Current maximum liability: $6,313,567,211
Proposed maximum liability: $6,313,567,211

After review, the Fiscal Review Committee voted to recommend approval of the contract amendment with a recommendation that the trip manifests be provided to non-emergency medical transportation (NEMT) providers two days prior to the service and with the stipulation that the Bureau submit a monthly status report relative to the NEMT.

cc: The Honorable Darin Gordon, Deputy Commissioner

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

March 28, 2013

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: MCO Contract Amendments - (7)
HP Enterprise Services, LLC (formerly EDS) - Amendment #1
Oregon Health and Science University – Center for Evidence Based Policy

Dear Mr. Geise:

The Department of Finance and Administration, Division of Health Care Finance and Administration, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments. The MCO contracts provide medical and behavioral health services to TennCare enrollees. The proposed amendment contains the following language updates: (1) Revises requirements around circumstances necessitating member signature on the CHOICES Plan of Care; (2) Adds language regarding ADA requirements; (3) Clarifies Member Material Requirements and adds an Annual Evaluation of MCO Outreach Plans; (4) Adds clarity around CHOICES requirements to secure accurate address/contact information; (5) Adds clarity around emergency plans for CHOICES enrollees; (6) Updates CHOICES Caseload requirements; (7) Updates language to reflect Group 3 CHOICES members are not eligible for MFP; (8) Revises Pay for Performance Language to allow TennCare to choose future benchmarks based on specific MCO needs for improvement; (9) Adds language to facilitate pass-through of pharmacy costs to the pharmacy benefits manager, and (10) Additional contract language clarifications to update references regarding Individuals with Intellectual Disabilities. No funds are required to support the changes in this amendment.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-32
AMERIGROUP Tennessee, Inc.	FA-07-16936-15
UnitedHealthCare Plan of the River Valley, Inc.	FA-07-16937-15
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-12
Volunteer State Health Plan (West Region)	FA-08-24978-12
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-12
Volunteer State Health Plan (East Region)	FA-08-24983-12

Also submitted for review is amendment #1 to HP Enterprise Services, LLC (formerly EDS). This contract is for the operation, management, and enhancement of the TennCare Management Information Systems. This amendment is to continue system management by execution of term extension, provide new enhancements and projects, and provide funding to support the term extension of the contract. These projects include Service Oriented Architecture infrastructure, in support of Modularity (1 of the 7 new CMS Standards and Conditions for enhanced Federal Financial Participation); Enterprise Provider Portal framework to promote provider self-service and strengthen the framework for provider access security management; extension of ICD-10 deployment project based on revised CMS schedule, and provide supplemental support for extensive system changes related to federal mandates.

Finally, TennCare is requesting approval of a non competitive contract with Oregon Health and Science University, Center for Evidence Based Policy. The Contractor organizes and administers the Medicaid Evidence-Based Decisions (MED) Project and the Drug Effectiveness Review Project (DERP) to create an effective collaboration among Medicaid programs and their state partners for the purpose of making high quality evidence analysis available to support benefit design and coverage decisions made by state programs to align goals and resources that enable states to achieve results and impact policy they may be unable to achieve individually. Oregon Health & Science University, Center for Evidence-Based Policy (CEBP), is the sole provider of Medicaid focused collaboratives, related to the specific areas of diagnostics, devices, programs, procedures, and medications, founded to produce evidence reports for its members and explicitly governed by the members themselves. Because of CEBP's status as the sole provider of these unique services and the specific expertise and resources provided through this collaboration, contracting with CEBP is considered to be in the best interest of the State.

The Department of Finance and Administration, Division of Health Care Finance and Administration, appreciates consideration of these amendments by the Fiscal Review Committee and respectfully requests approval.

Sincerely,

Casey Dungan
Chief Financial Officer

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	29634	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	15
Proposed Amendment Effective Date: *(if applicable)*	June 1, 2013
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	March 28, 2013
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$6,313,567,211.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00
FY: 2013					
$989,205,835.00					

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$848,507,847.90
FY: 2013					
$698,891,420.43					

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.

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:	$2,067,717,045.00	Federal:	$4,245,850,166.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.

Supplemental Documentation Required for Fiscal Review Committee

Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.
Amendment #10 – January 1, 2012	Program Integrity Updates, HIPAA/HITECH clarifications; CHOICES updates; Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; Increase funding to support the services for this contract for FY '12 and FY '13 based on actual expenditures
Amendment #11 – March 1, 2012	Added language to clarify that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility.
Amendment #12 – July 1, 2012	Added requirements for the Contractor regarding the implementation and operation of CHOICES Group 3, language to clarify that QM/QI reporting must be specific to TennCare and not combined with other state or commercial programs, Program Integrity language to clarify PI Investigators be designated by plan, SSA Data Security language added in accordance with our agreement with SSA, and Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. No additional funding is required relative to this amendment.
Amendment #13 – January 1, 2013	(1) Replaces Disease Management requirements with Population Health requirements; (2) Clarification regarding the implementation of CHOICES 3 requirements; (3) Clarification language as requested by CMS regarding TPL and PETI; (4) Include requirement to support CMS require PCP rate increase for 2013/2014; (5) Include requirement to participate and implement initiatives to capture Prenatal and Postnatal visit data; (6) Coordination requirements for MCOs regarding DSNPs; (7) Updates the transportation requirements to reflect current reporting needs and support audit efforts, and (8) provides contract funding for FY '14.
Amendment #14 – March 15, 2013	Added language requested by the Center for Medicare and Medicaid Services (CMS) regarding the Primary Care Rate Bump Final Rule as required by the Affordable Care Act.
Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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).

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.

Supplemental Documentation Required for Fiscal Review Committee

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.

CONTRACT SUMMARY SHEET

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-14

State Agency	State Agency Division
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
TOTAL:	**$ 2,067,717,045.00**	**$ 4,245,850,166.00**	**$ -**	**$ -**	**$ 6,313,567,211.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ 989,205,835.00	
TOTAL:	**$ 6,313,567,211.00**	**$ -**
End Date	December 31, 2014	

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg.ID.GG.GU) [ ] Other

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

UnitedHealthCare Plan (Americhoice) - Middle

FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL $1,051,885,932.05

UnitedHealthCare Plan (Americhoice) - Middle

FY 2012

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00357932	0000021799	80,164,116.78	8/1/2011
31865	00357935	0000021799	1,749.12	8/1/2011
31865	00373132	0000021799	66,259,994.41	9/2/2011
31865	00373135	0000021799	4,290.68	9/2/2011
			146,430,150.99	
31865	00390204	0000021799	68,500,422.24	10/7/2011
31865	00390207	0000021799	1,970.72	10/7/2011
31865	00396234	0000021799	16,338,030.88	10/17/2011
31865	00396235	0000021799	189,155.42	10/17/2011
31865	00404008	0000021799	77,882,668.64	11/4/2011
31865	00404011	0000021799	1,159.98	11/4/2011
31865	00417176	0000021799	66,848,857.76	12/5/2011
31865	00417179	0000021799	37.42	12/5/2011
			229,762,303.06	
31865	101519377	0000021799	76,652,274.04	1/6/2012
31865	101547443	0000021799	84,528,169.47	2/3/2012
31865	101574349	0000021799	78,374,720.09	3/2/2012
31865	101538873	0000021799	12,350.00	2/1/2012
			239,567,513.60	
31865	101608051	0000021799	77,495,120.45	4/5/2012
31865	101621414	0000021799	1,300.00	4/23/2012
31865	101628167	0000021799	12,000.00	4/27/2012
31865	101635082	0000021799	79,019,045.16	5/4/2012
31865	101662448	0000021799	76,220,414.64	6/1/2012
			232,747,880.25	

FY 2012 TOTAL $ 848,507,847.90

UnitedHealthCare Plan (Americhoice) - Middle

FY 2013

Unit	Voucher ID	Vendor ID		Amount Pd	Pymnt Date
31865	101696065	0000021799	$	77,600,771.38	7/6/2012
31865	101723402	0000021799	$	79,380,930.51	8/3/2012
31865	101758287	0000021799	$	77,957,765.92	9/7/2012
				234,939,467.81	
31865	00583536	0000021799		77,555,656.30	10/5/2012
31865	00590779	0000021799		44,000.00	10/19/2012
31865	00598074	0000021799		78,885,213.03	11/2/2012
31865	00615111	0000021799		77,726,345.44	12/7/2012
				234,211,214.77	
31865	00628398	0000021799		77,085,082.13	1/4/2013
31865	00643397	0000021799		75,386,077.57	2/1/2013
31865	00660941	0000021799		77,184,578.15	3/1/2013
31865	00665243	0000021799		85,000.00	3/8/2013
				229,740,737.85	

FY 2013 TOTAL $ 698,891,420.43

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED
CENTRAL PROCUREMENT OFFICE

Request Tracking #	**31866-00051**
Procuring Agency	**Department of Finance and Administration Bureau of TennCare**
Contractor	**UnitedHealthCare Plan of the River Valley, Inc.**
Contract #	**FA-07-16937-00**
Proposed Amendment #	**15**
Edison ID #	**29634**

Contract Begin Date	**August 15, 2006**
Current Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Proposed Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Current Maximum Contract Cost *– with ALL options to extend exercised*	**$6,313,567,211.00**
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	**$6,313,567,211.00**
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	**X Not Applicable** ☐ **Attached**
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	**X Not Applicable** ☐ **Attached**
Human Resources Support *– state employee training service*	**X Not Applicable** ☐ **Attached**

Explanation Need for the Proposed Amendment

This competitively procured contract provides medical and behavioral health services to TennCare enrollees. The proposed amendment contains the following language updates: (1) Revises requirements around circumstances necessitating member signature on the CHOICES Plan of Care; (2) Adds language regarding ADA requirements; (3) Clarifies Member Material Requirements and adds an Annual Evaluation of MCO Outreach Plans; (4) Adds clarity around CHOICES requirements to secure

Request Tracking #	31866-00051

accurate address/contact information; (5) Adds clarity around emergency plans for CHOICES enrollees; (6) Updates CHOICES Caseload requirements; (7) Updates language to reflect Group 3 CHOICES members are not eligible for MFP; (8) Revises Pay for Performance Language to allow TennCare to choose future benchmarks based on specific MCO needs for improvement; (9) Adds language to facilitate pass-through of pharmacy costs to the pharmacy benefits manager, and (10) Additional housekeeping changes to update references regarding Individuals with Intellectual Disabilities. No funds are required to support the changes in this amendment.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to provide language requirements surrounding the CHOICES Plan of Care, CHOICES caseload requirements, member material and Outreach Evaluation of MCO outreach plans, revise Pay for Performance, add language to facilitate pass-thru of Pharmacy costs to the PBM and additional housekeeping changes to update references regarding Individuals with Developmental Disabilities. No funds are required to support the changes in this amendment. The Bureau of TennCare respectfully requests review and approval of this contract amendment.

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark D. Emkes 2/26/13

CONTRACT SUMMARY SHEET

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-15

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
TOTAL:	$ 2,067,717,045.00	$ 4,245,850,166.00	$ -	$ -	**$ 6,313,567,211.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ 989,205,835.00	
TOTAL:	**$ 6,313,567,211.00**	$ -
End Date	December 31, 2014	

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg.ID,GG,GU) [ ] Other

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

AMENDMENT NUMBER 15
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. Section 1 shall be amended by adding the following definitions:

Individuals with Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Oral Interpretation - Is the act of listening to something in one language (source language) and orally translating it into another language (target language).

Vital Documents - Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents) and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

Written Translation - Is the replacement of a written text from one language (source language) into an equivalent written text in another language (target language).

2. Section 1 shall be amended by deleting the definition for "Vital MCO Documents".

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

Eligible Individual – With respect to Tennessee's Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State's approved MFP Operational Protocol and TennCare Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Nursing Facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.

   a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

   b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

   c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., not covered by Medicare) as a cost-effective alternative (see Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.

2. Be eligible for and receive Medicaid benefits for inpatient services furnished by the nursing facility or ICF/IID for at least one (1) day. For purposes of this Agreement, an Eligible Individual must reside in a nursing facility and be enrolled in CHOICES Group 1 for a minimum of one (1) day and must be eligible to enroll and transition seamlessly into CHOICES Group 2 without delay or interruption.

3. Meet nursing facility or ICF/IID level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

Long-Term Care (LTC) – The services of a nursing facility (NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Home and Community-Based Services (HCBS). These services may also be called Long-Term Services and Supports (LTSS).

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a nursing facility or ICF/IID into a Qualified Residence in the

community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

Qualified Institution – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/ID.

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under the Affordable Care Act.

4. Section 2.2.3 shall be deleted and replaced as follows:

2.2.3 If the CONTRACTOR is part of a health maintenance organization holding company system as defined by TCA 56-11-101(b)(5), the CONTRACTOR agrees to comply with the Insurance Holding Company System Act of 1986 as set forth in TCA 56-11-101 et seq. The CONTRACTOR agrees to comply with the requirements of TCA 56-11-101 et seq. whether the CONTRACTOR is domiciled in Tennessee or is a foreign health maintenance organization subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to this contained in TCA 56-11-101 et seq. If the CONTRACTOR is a foreign domiciled health maintenance organization, the manner in which the CONTRACTOR shall comply with the requirements of TCA 56-11-101 et seq. are outlined in a Memorandum of Understanding between the CONTRACTOR and the Tennessee Department of Commerce and Insurance, TennCare Oversight Division, which is incorporated herein by reference. The information disclosed or filed in accordance with the requirements of TCA 56-11-101 et. seq. shall be considered Confidential Information pursuant to TCA 56-11-108.

5. Section 2.4.6.1 shall be amended by adding a new sentence to the end of the existing text as follows:

2.4.6.1 The CONTRACTOR shall receive, process, and update outbound 834 enrollment files from TENNCARE. Enrollment data shall be updated or uploaded systematically to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

6. **Section 2.6.1.5.4 shall be amended by adding new Section 2.6.1.5.4.1 through 2.6.1.5.4.1.2 as follows:**

2.6.1.5.4.1 The CONTRACTOR shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

2.6.1.5.4.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year. However, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

2.6.1.5.4.1.2 Upon request, the CONTRACTOR shall provide to TENNCARE a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, and the anticipated date of discharge back to the community.

7. **Section 2.6.2.3 shall be amended by deleting and replacing the reference "ICF/MR" with "ICF/IID", replacing the reference "Intermediate Care Facility for the Mentally Retarded (ICF/MR)" with "Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)" and deleting the phrase "(i.e., mental retardation)".**

8. **Section 2.7.4.1.12 shall be amended by adding the phrase ", at least annually," as follows:**

2.7.4.1.12 Education, at least annually, for members and caregivers about identification and reporting of suspected abuse and neglect;

9. **Section 2.7.4.2.1 shall be deleted and replaced as follows:**

2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; all proposed community/health education events unrelated to TENNderCare; and a process for evaluating the benefits of the events. An Annual Evaluation of the Plan shall be due no later than ninety (90) days following the end of a calendar year in a format approved by TENNCARE.

CENTRAL PROCUREMENT

10. Section 2.7.4.2 shall be amended by adding a new Section 2.7.4.2.4 as follows:

2.7.4.2.4 The CONTRACTOR shall submit an *Annual Community Outreach Evaluation* of the approved Annual Community Outreach Plan no later than ninety (90) days following the end of a calendar year. The Evaluation shall include, but is not limited to, an assessment of the events that were conducted in the previous year as well as of the objectives that were identified in the CONTRACTOR'S Community Outreach Plan.

11. Section 2.7.6.3.3.5 shall be amended by deleting and replacing the phrase "ten (10) ug/dL" with the phrase "five (5) ug/dL" as follows:

2.7.6.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than five (5) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and

12. Section 2.7.6.4.7.1 shall be deleted and replaced as follows:

2.7.6.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels. Determining elevated blood levels requiring follow-up shall be in accordance with current CDC guidelines. Elevated blood lead follow up guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

13. Section 2.8.2.1.1 shall be deleted and replaced as follows:

2.8.2.1.1 <u>Level 0</u>- The members eligible to participate at this Level shall be determined by predictive modeling to meet ALL of the following criteria: no identified health risks; no identified chronic conditions [as identified by the Chronic Condition tool created by the Agency for Healthcare Research and Quality's (AHRQ) HCUP database]; and no indication of pregnancy; or no claims history.

14. Section 2.8.4.6 shall be amended by deleting and replacing the reference from "Sections 2.8.2.3 and 2.8.2.3.1" to "Sections 2.8.2.2 and 2.8.2.2.1".

15. Section 2.8.11 shall be amended by adding a new Section 2.8.11.5 as follows:

2.8.11.5 The CONTRACTOR shall submit at the beginning of each quarter, through the current secure system, a list in Comma Separated Value (CSV) format consisting of the name, ID, DOB, stratification or risk level and dates of eligibility for level for all MCO members.

16. Section 2.8.13 through 2.8.13.6 shall be deleted and replaced as follows:

2.8.13 **Milestones for the Sixth Month (January 1 to July 1, 2013) Transition Period from Disease Management to Population Health**

2.8.13.1 The CONTRACTOR shall by July 1, 2013 have operationalized Population Health to provide all minimum interventions to enrollees who are not participating in a medical home lock in project, in the appropriate programs.

17. Section 2.9.6.2.3.4 shall be deleted and replaced as follows:

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) document and confirm the applicant's current address and phone number(s); (2) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) provide information about estate recovery; (4) complete Medicaid and level of care (i.e., PAE) applications and provide assistance, as necessary, in gathering documentation needed by the State to determine TennCare eligibility; (5) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (6) for applicants seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (7) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; (8) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (9) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment in accordance with protocols developed by TENNCARE and discuss with the applicant identified risks of receiving care in the home or community-based setting, the consequences of such risks, and strategies to mitigate the identified risks; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (10) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

18. Section 2.9.6.2.3.7 shall be amended by adding a new phrase as follows:

2.9.6.2.3.7 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's current address and phone number(s), the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and documentation of the discussion regarding identified risk and mitigation strategies.

19. Section 2.9.6.3.9 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) document and confirm the applicant's current address and phone number(s) and assist the member in updating his or her address with DHS or the Social Security Administration, if applicable; (2) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (3) provide information about estate recovery; (4) provide assistance, as necessary, in gathering documentation needed by DHS to determine categorical/financial eligibility for LTC; (5) for members seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (6) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (7) for members who want to receive nursing facility services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (8) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall document identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk, and which shall also be signed by the care coordinator, attesting that such risks and strategies have been discussed with the member or his/her representative prior to their decision to accept such risk; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (9) for members seeking enrollment in Group 2, make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; (10) for members seeking enrollment in Group 3, provide explanation to the member regarding the fifteen thousand dollar ($15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and (11) for all members, using current information regarding the CONTRACTOR's network, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

20. Section 2.9.6.3.20 shall be amended by adding a new Section 2.9.6.3.20.2 and renumbering the remaining Section accordingly, including any references thereto:

2.9.6.3.20.2 Notwithstanding the phone number in the 834 file, for purposes of the EVV system (see Section 2.9.6.12.5.), the CONTRACTOR shall use the member's phone number or appropriate alternative phone number as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5), through EVV alert monitoring or other member contacts for all HCBS that will be logged into the EVV system.

21. The renumbered Section 2.9.6.3.20. shall be amended by adding a new Section 2.9.6.3.20.11 as follows:

2.9.6.3.20.11 Upon receiving notification from TENNCARE that a member's eligibility has ended, the CONTRACTOR shall within two (2) business days notify all providers of ongoing HCBS that the member's CHOICES eligibility has ended, which may be accomplished by notification in the EVV system. Such notification shall not be provided in advance of the actual end date of member's CHOICES eligibility, as a prospective end date could be extended.

22. Section 2.9.6.6.2.4 shall be deleted and replaced as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled in CHOICES Group 2 on the basis of Immediate Eligibility who shall have access to services beyond the limited package of CHOICES HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, the schedule at which such care is needed, and the phone number(s) that will be used to log visits into the EVV system, as applicable; members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of

CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

23. Section 2.9.6.6.2.5.6 and 2.9.6.6.2.5.7 shall be deleted and replaced as follows and Section 2.9.6.6.2.5.8 shall be deleted in its entirety. The remaining Section 2.9.6.6.2.5 shall be renumbered accordingly, including any references thereto.

2.9.6.6.2.5.6 A person-centered statement of goals, objectives and desired health, functional and quality of life outcomes for the member and how CHOICES services are intended to help the member achieve these goals;

2.9.6.6.2.5.7 Description of other services that will be provided to the member, including (1) covered physical health services, including population health services, that will be provided by the CONTRACTOR to help the member maintain or improve his or her physical health status or functional abilities and maximize independence; (2) covered behavioral health services that will be provided by the CONTRACTOR to help the member maintain or improve his or her behavioral health status or functional abilities and maximize independence; (3) other psycho/social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and (4) any non-covered services including services provided by other community resources, including plans to link the member to financial assistance programs including but not limited to housing, utilities and food as needed;

24. The renumbered Section 2.9.6.6.2.5.12 shall be deleted and replaced as follows:

2.9.6.6.2.5.12 Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;

2.9.6.6.2.5.12.1 Planning what to do during an emergency shall include, but may not be limited to the following:

2.9.6.6.2.5.12.1.1 Developing an emergency plan;

2.9.6.6.2.5.12.1.2 Creating a plan to have shelter in place when appropriate;

2.9.6.6.2.5.12.1.3 Creating a plan to get to another safe place when appropriate; and

2.9.6.6.2.5.12.1.4 Identifying, when possible, two ways out of every room in case of fire.

2.9.6.6.2.5.12.2 Identify any additional steps the member and/or representative should take in the event of an emergency.

25. Section 2.9.6.6.2.6 shall be amended by adding additional language as follows:

2.9.6.6.2.6 The member's care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any substantive updates, including but not limited to any changes in the amount, duration or type of HCBS that will be provided. The care coordinator shall also sign and date the plan of care, along with any substantive updates. The plan of care shall be updated and signed by the member and the care coordinator annually and any time the member experiences a significant change in needs or circumstances (see Section 2.9.6.9.2.1.16).

26. Section 2.9.6.6.2.6 shall be amended by adding a new Section 2.9.6.6.2.6.4 which shall read as follows:

2.9.6.6.2.6.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member;however, all schedule changes must be member-initiated; 3) changes in the member's current address and phone number(s) or the phone number(s) that will be used to log visits into the EVV system; or 4)instances as permitted pursuant to TennCare policies and protocols. Documentation of such changes shall be maintained in the member's records.

27. Section 2.9.6.8.26.4 and 2.9.6.8.26.4.1 shall be deleted in their entirety and the remaining Section 2.9.6.8 shall be renumbered accordingly, including any references thereto.

28. Section 2.9.6.9.2.1 shall be amended by adding a new Section 2.9.6.9.2.1.5 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.9.2.1.5 Document and confirm the applicant's current address and phone number(s) or appropriate alternative phone number(s) that the member's service provider will use to call in/out for the purpose of logging visits into the EVV system, and assist the member in updating his or her address with DHS or the Social Security Administration, if applicable;

29. Section 2.9.6.9.4.3.7 shall be amended by deleting the phrase "or Group 3".

30. Section 2.9.6.9.4.3 shall be amended by adding a new Section 2.9.6.9.4.3.8 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.9.4.3.8 Members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly (more frequently when appropriate based on the member's needs and/or request which shall be documented in the plan of care). Such contacts shall be either in person or by telephone with an interval of at least sixty (60) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least semi-annually (more frequently when appropriate based on the member's needs and/or request which shall be documented in the plan of care) with an interval of at least one hundred-twenty (120) days between visits.

31. Section 2.9.6.10.16 shall be deleted and replaced as follows:

2.9.6.10.16 If at anytime abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and shall provide, at least annually, education of the member and his/her representative of the risk of, and signs and symptoms of, abuse and neglect. The CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

32. Section 2.9.6.11.6.2 through 2.9.6.11.6.4 shall be deleted and replaced as follows and the remaining Section 2.9.6.11.6 shall be renumbered accordingly, including any references thereto.

2.9.6.11.6.2 Each CHOICES Group 2 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5);

2.9.6.11.6.3 Each CHOICES Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of one and three quarters (1.75);

2.9.6.11.6.4 Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125:

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
125	0		125
100	10		110
50	9	30	89
25	26	20	71
0	50		50

2.9.6.11.6.5 Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175:

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
175	0		175
125	10		110
75	19	30	124
50	36	20	106
0	70		70

33. Section 2.9.6.12 shall be amended by adding new Sections 2.9.6.12.3 through 2.9.6.12.4.4 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.12.3 The CONTRACTOR shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Agreement, and with policies and protocols established by TENNCARE. The CONTRACTOR shall notify TENNCARE within five (5) business days of the identification of any issue affecting EVV system operation which impacts the CONTRACTOR's performance of this Agreement, including actions that will be taken by the CONTRACTOR to resolve the issue and the specific timeframes within which such actions will be completed.

2.9.6.12.4 The CONTRACTOR shall establish business processes and procedures which shall include a standard process by which providers may notify the CONTRACTOR of exceptions for which an action by the CONTRACTOR is required for resolution and shall maintain an adequate number of qualified, trained staff to support the operation of the EVV system. These staff will ensure that:

2.9.6.12.4.1 Authorizations as defined pursuant to 2.9.6.2.5.12. are entered into the EVV system timely and accurately, including any changes in such authorizations based on changes in the member's plan of care.

2.9.6.12.4.2 Authorizations provided by the CONTRACTOR outside the EVV system are consistent with authorizations entered by the CONTRACTOR into the EVV system and with the member's currently approved plan of care.

2.9.6.12.4.3 Any actions required by the CONTRACTOR to resolve exceptions in the EVV system, e.g., a change in the service authorization, are completed within three (3) business days so that claims for services can be submitted for payment.

2.9.6.12.4.4 The CONTRACTOR monitors on an ongoing basis and reports to TENNCARE upon request, the total volume of CHOICES HCBS that have been provided but not reimbursed due to issues with the EVV system or due to individual exceptions, and proactively works with providers and the FEA to ensure that issues are corrected and exceptions are resolved as expeditiously as possible and within the timeframes specified above in order to provide payment as appropriate for services delivered.

34. The renumbered Section 2.9.6.12.5 shall be amended by deleting the phrase "homemaker services".

35. Section 2.9.6.12 shall be amended by adding a new Section 2.9.6.12.7 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.12.7 Notwithstanding the phone number in the 834 file, the CONTRACTOR shall use the member's phone number or appropriate alternative phone number as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5.) for all HCBS that will be logged into the EVV system.

36. Section 2.9.7.1.1 shall be amended by deleting "homemaker," in the first sentence.

37. Section 2.9.8 shall be deleted and replaced as follows:

2.9.8 **Money Follows the Person (MFP) Rebalancing Demonstration**

2.9.8.1 General

2.9.8.1.1 The CONTRACTOR shall, in accordance with this Agreement and federal and State laws, regulations, policies and protocols, assist Eligible Individuals living in a Qualified Institution in transitioning to a Qualified Residence in the community under the State's MFP Rebalancing Demonstration (MFP).

2.9.8.1.2 Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from CHOICES Group 1 into CHOICES Group 2 pursuant to TennCare policies and protocols for Nursing Facility-to-community transitions and shall also be enrolled into MFP. For persons enrolled in CHOICES who are also participating in MFP, the CONTRACTOR shall comply with all applicable provisions of this Agreement pertaining to the CHOICES program. This section sets forth additional requirements pertaining to the CONTRACTOR's responsibilities specifically as it relates to MFP.

2.9.8.1.3 For CHOICES Group 1 members not eligible to participate in MFP or who elect not to participate in MFP, the CONTRACTOR shall nonetheless facilitate transition to the community as appropriate and in accordance with 2.9.6.8.

2.9.8.1.4 The CONTRACTOR shall not delay a CHOICES Group 1 member's transition to the community in order to meet the ninety (90)-day minimum stay in a Qualified Institution established under ACA and enroll the person into MFP.

2.9.8.2 Identification of MFP Participants

2.9.8.2.1 The CONTRACTOR shall identify members who may have the ability and/or desire to transition from a nursing facility to the community in accordance with Section 2.9.6.8.

2.9.8.2.2 The CONTRACTOR shall assess all nursing facility residents transitioning from the NF to CHOICES Group 2 for participation in MFP. This includes CHOICES Group 1 members referred for transition, as well as nursing facility residents referred for CHOICES who are not

yet enrolled in CHOICES Group 1 but may be determined eligible for Group 1, and who have expressed a desire to move back into the community. However, the resident must actually be enrolled into Group 1 in order to qualify for MFP.

2.9.8.2.3 Members may only elect to participate in MFP and the CONTRACTOR may only enroll a member into MFP prior to the member's transition from the nursing facility to the community. Members will not be eligible to enroll in MFP if they have already transitioned out of the nursing facility.

2.9.8.3 Eligibility/Enrollment into MFP

2.9.8.3.1 Member participation in MFP is voluntary. Members may deny consent to participate in MFP or may withdraw consent to participate in MFP at any time without affecting their enrollment in CHOICES.

2.9.8.3.2 If a member withdraws from MFP, he cannot participate in MFP again without meeting the eligibility requirements for enrollment into MFP (e.g., following a ninety (90)-day stay in a Qualified Institution).

2.9.8.3.3 Only CHOICES Group 1 members who qualify to enroll in CHOICES Group 2 shall be eligible to transition to Group 2 and enroll into MFP.

2.9.8.3.4 In addition to facilitating transition from CHOICES Group 1 to CHOICES Group 2 pursuant to Section 2.9.6.8 of this Agreement and TENNCARE's policies and protocols, the CONTRACTOR shall facilitate the enrollment of Eligible Individuals who consent into MFP.

2.9.8.3.5 The member's care coordinator or, if the CONTRACTOR elects to use transition teams, a person who meets the qualifications of a care coordinator shall, using information provided by TENNCARE, provide each potential MFP participant with an overview of MFP and answer any questions the participant has. The CONTRACTOR shall have each potential MFP participant or his authorized representative, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by the CONTRACTOR and documenting the member's decision regarding MFP participation.

2.9.8.3.6 Once a potential MFP participant has consented to participate in MFP, the CONTRACTOR shall notify TENNCARE within two (2) business days via the TENNCARE PreAdmission Evaluation System (TPAES) unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.3.7 The CONTRACTOR shall verify that each potential MFP participant is an Eligible Individual and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.3.8 The CONTRACTOR shall verify that each potential MFP participant will transition into a Qualified Residence in the community and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.3.9 Final determinations regarding whether a member can enroll into MFP shall be made by TENNCARE based on information provided by the CONTRACTOR.

2.9.8.3.10 TENNCARE may request and the CONTRACTOR shall submit in a timely manner additional documentation as needed to make such determination. Documentation submitted by the CONTRACTOR may be verified, to the extent practicable, by other information, either prior or subsequent to enrollment in MFP, including eligibility, claims and encounter data.

2.9.8.4 Participation in MFP

2.9.8.4.1 The participation period for MFP is 365 days. This includes all days during which the member resides in the community, regardless of whether CHOICES HCBS are received each day. Days are counted consecutively except for days during which the member is admitted to an inpatient facility.

2.9.8.4.2 The participation period for MFP does not include any days during which the member is admitted to an inpatient facility.

2.9.8.4.3 MFP participation will be "suspended" in the event a member is re-admitted for a short-term inpatient facility stay. Member will not have to re-qualify for MFP regardless of the number of days the member is in the inpatient facility, and shall be re-instated in MFP upon return to a Qualified Residence in the community.

2.9.8.4.4 It may take longer than 365 calendar days to complete the 365-day MFP participation period days since a member's participation period may be interrupted by one or more inpatient facility stays.

2.9.8.4.5 For MFP participants, a significant change in circumstances (see 2.9.6.9.2.1.16.) shall include any admission to an inpatient facility, including a hospital, psychiatric hospital, PRTF, nursing facility or Medicare-certified Skilled Nursing Facility. The member's Care Coordinator shall (pursuant to 2.9.6.2.4) visit the member face-to-face within five (5) business days of any inpatient facility admission and shall assess the member's needs, conduct a comprehensive needs assessment and update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances. If the visit is conducted in the inpatient facility, the CONTRACTOR may elect to have someone who meets the qualifications of a Care Coordinator complete the required face-to-face visit and conduct a comprehensive needs assessment, in which case, the qualified individual conducting the face-to-face visit shall coordinate with the member's Care Coordinator to update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.

2.9.8.4.6 The CONTRACTOR shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that continued participation in CHOICES Group 2 and in MFP is appropriate.

2.9.8.4.7 The CONTRACTOR shall notify TENNCARE within five (5) business days of admission any time a member is admitted to an inpatient facility. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain

supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.4.7.1 For purposes of MFP, admission for observation (which is not considered inpatient care) shall not be considered admission to an inpatient facility. Nor shall participation in MFP be suspended during observation days.

2.9.8.4.8 The CONTRACTOR shall be involved in discharge planning on behalf of any MFP participant admitted to an inpatient facility.

2.9.8.4.9 The CONTRACTOR shall notify TENNCARE within two (2) business days when an MFP participant is discharged from a short-term stay in an inpatient facility. Such notification shall include whether the member is returning to the same Qualified Residence in which he lived prior to the inpatient stay, or a different residence which shall also be a Qualified Residence. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.4.10 If at any time during the member's participation in MFP, the member changes residences, including instances in which the change in residences occurs upon discharge from an inpatient facility stay, the CONTRACTOR shall: 1) notify TENNCARE within two (2) business days of the change in residence; 2) verify that the new residence is a Qualified Residence; and 3) provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.4.11 The CONTRACTOR shall track the member's residency throughout the 365-day MFP participation period. In addition, the CONTRACTOR shall, for purposes of facilitating completion of Quality of Life surveys, continue to track MFP participants' residency for two (2) years following transition to the community which may be up to one (1) year following completion of the MFP participation period, or until the member is no longer enrolled in the CONTRACTOR's health plan.

2.9.8.4.12 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice of MFP participation to each member enrolled in MFP which shall not occur prior to transition from CHOICES Group 1 to CHOICES Group 2. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is enrolled in MFP.

2.9.8.4.13 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice to each member upon conclusion of the 365-day participation period. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is no longer enrolled in MFP.

2.9.8.4.14 A member who successfully completes 365-day participation period for MFP and is subsequently re-institutionalized may qualify to participate in MFP again but must first meet the "Eligible Individual" criteria. There shall be a minimum of ninety (90) days between MFP participation occurrences. Prior to enrollment in a second MFP occurrence, the care coordinator shall assess the reason for the re-institutionalization to determine if the member is

an appropriate candidate for re-enrollment in MFP and if so, shall develop a plan of care (including a Risk Agreement) that will help to ensure that appropriate supports and services are in place to support successful transition and permanency in the community.

2.9.8.5 Plan of Care

2.9.8.5.1 For members participating in the MFP, the Plan of Care shall reflect that the member is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from CHOICES Group 1 to CHOICES Group 2).

2.9.8.5.2 Upon conclusion of the member's 365-day participation period in MFP, the Plan of Care shall be updated to reflect that he is longer participating in MFP.

2.9.8.6 Services

2.9.8.6.1 A member enrolled in MFP shall be simultaneously enrolled in CHOICES Group 2 and shall be eligible to receive covered benefits as described in 2.6.1.

2.9.8.7 Continuity of Care

2.9.8.7.1 Upon completion of a person's 365-day participation in MFP, services (including CHOICES HCBS) shall continue to be provided in accordance with the covered benefits described in 2.6.1 and the member's plan of care. Transition from participation in MFP and CHOICES Group 2 to participation *only* in CHOICES Group 2 shall be seamless to the member, except that the CONTRACTOR shall be required to issue notice of the member's conclusion of his 365-day MFP participation period.

2.9.8.8 Level of Care and Short-Term Nursing Facility Stay in MFP

2.9.8.8.1 In order to enroll in MFP, a member must meet NF LOC. Group 3 members are not eligible for MFP.

2.9.8.8.2 A CHOICES Group 2 member participating in MFP who meets the nursing facility level of care in place at the time of admission may be admitted for an inpatient short-term nursing facility stay during his 365-day participation period and remain enrolled in MFP regardless of the number of days the member is admitted for inpatient facility care.

2.9.8.8.3 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.

2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 to CHOICES Group 1.

2.9.8.8.5 The member's care coordinator shall monitor the member's inpatient stay and shall visit the member face-to-face at least monthly during the inpatient stay or more frequently as necessary to facilitate timely and appropriate discharge planning.

2.9.8.8.6 The CONTRACTOR shall conduct a Transition Assessment and develop a Transition Plan (see Section 2.9.6.8) as necessary to facilitate the member's return to the community. Such

assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 and continued participation in MFP is appropriate. The CONTRACTOR shall update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.

2.9.8.8.7 Upon discharge from the short-term stay, within one (1) business day, the care coordinator shall visit the member in his/her Qualified Residence. During the ninety (90) days following transition and re-instatement into MFP, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community.

2.9.8.8.8 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.

2.9.8.8.9 Days that are spent in an inpatient facility, including short-term nursing facility stays, do not count as part of the member's 365-day MFP participation period.

2.9.8.9 <u>TPAES</u>

2.9.8.9.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES) to facilitate enrollments into and transitions between LTC programs, including CHOICES and the State's MFP Rebalancing Demonstration (MFP), and shall comply with all data collection processes and timelines established by TENNCARE in policy or protocol in order to gather data required to comply with tracking and reporting requirements pertaining to MFP. This shall include (but is not limited to) attestations pertaining to Eligible Individual and Qualified Residence, changes of residence, inpatient facility admissions and discharges, reasons for re-institutionalization, and reasons for disenrollment from MFP.

2.9.8.10 <u>IT requirements</u>

2.9.8.10.1 Pursuant to Section 2.23 of this Agreement, the CONTRACTOR shall modify its information systems to accommodate, accept, load, utilize and facilitate accurate and timely reporting on information submitted to by TENNCARE via the outbound 834 file that will identify MFP participants, as well as those MFP participants in suspended status during an inpatient admission.

2.9.8.11 <u>Case Management System</u>

2.9.8.11.1 The CONTRACTOR's case management system (see Section 2.9.6.12.7) shall identify persons enrolled in MFP and shall generate reports and management tools as needed to facilitate and monitor compliance with contract requirements and timelines.

2.9.8.12 MFP Readiness Review

2.9.8.12.1 Prior to implementation of MFP, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that the CONTRACTOR is able to meet all of the requirements pertaining to MFP set forth in this Agreement.

2.9.8.12.2 The CONTRACTOR shall cooperate in a "readiness review" conducted by TENNCARE to review the CONTRACTOR's readiness to fulfill its obligations regarding MFP in accordance with the Agreement. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all MFP requirements of the Agreement as determined by TENNCARE.

2.9.8.12.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

2.9.8.13 MFP Benchmarks

2.9.8.13.1 The CONTRACTOR shall assist TENNCARE in meeting the five (5) annual benchmarks established for the MFP Rebalancing Demonstration which are described below in Sections 2.9.8.13.1.1 through 2.9.8.13.1.5.

2.9.8.13.1.1 *Benchmark # 1: Number of Persons Transitioned*

2.9.8.13.1.1.1 Assist the projected number of eligible individuals in each target group in successfully transitioning from an inpatient facility to a qualified residence during each year of the demonstration. Projected numbers:

Calendar Year	# of Elderly Transitioned	# of Disabled Adults Transitioned
2011	27	23
2012	206	169
2013	234	193
2014	261	214
2015	234	191
2016	206	169

2.9.8.13.1.1.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #1 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 1. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

2.9.8.13.1.2 *Benchmark #2: Qualified Expenditures for HCBS*

2.9.8.13.1.2.1 Increase the amount and percentage of Medicaid spending for qualified home and community based long-term care services during each year of the demonstration.

2.9.8.13.1.2.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.3 *Benchmark #3: Increased Amount and Percentage of HCBS Participants*

2.9.8.13.1.3.1 Increase the number and percentage of individuals who are elderly and adults with physical disabilities receiving Medicaid-reimbursed long-term care services in home and community based (versus institutional) settings during each year of the demonstration.

2.9.8.13.1.3.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

2.9.8.13.1.4 *Benchmark #4: Increase Unduplicated Contracted Community Based Residential Alternative*

2.9.8.13.1.4.1 Increase the number of unduplicated licensed CBRAs contracted with MCOs Statewide to provide HCBS in the CHOICES program during each year of the demonstration. Providers enrolled with more than one (MCO) or in more than one region shall only be counted once. Proposed numbers:

Calendar Year	# of MCO Contracted CBRAs Statewide
2011	70
2012	74
2013	78
2014	82
2015	86
2016	90

2.9.8.13.1.4.2 For purposes of incentive payments (See Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.5 *Benchmark #5: Increase Participation in Consumer Direction*

2.9.8.13.1.5.1 Increase the number of persons receiving Medicaid-reimbursed HCBS participating in consumer direction for some or all services during each year of the demonstration. Projected numbers:

Calendar Year	# in Consumer Direction
2011	600
2012	900
2013	1,150
2014	1,400
2015	1,550
2016	1,650

2.9.8.13.1.5.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #5 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 2 and Group 3. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

38. Section 2.9.11.1 shall be deleted and replaced as follows:

2.9.11.1 Except as provided in Section 2.6.1.3, the CONTRACTOR is not responsible for the provision of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall maintain an agreement with the PBM for the purpose of making payment to the PBM on behalf of TENNCARE for TennCare covered services. This requirement does not impose any further responsibilities on the CONTRACTOR regarding the provider's and/or provider's claims that are reimbursed through this payment structure. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section 3). The CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.

39. Section 2.9.15 through 2.9.15.3 shall be deleted and replaced as follows:

2.9.15 ICF/IID Services and Alternatives to ICF/IID Services

2.9.15.1 The CONTRACTOR is not responsible for services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to ICF/IID services (hereinafter referred to as "HCBS ID waiver"). However, to the extent that services available to a member through a HCBS ID waiver are also covered services pursuant to this Agreement, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS ID waiver services may supplement, but not supplant, medically necessary covered services. ICF/IID services and HCBS ID waiver services shall be provided

to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

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

2.9.15.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by ICF/IID and HCBS ID waiver providers to minimize disruption and duplication of services.

40. Section 2.11.1.10 shall be deleted and replaced as follows:

2.11.1.10 The CONTRACTOR shall monitor provider compliance with access requirements specified in Attachment III, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall maintain an emergency/contingency plan in the event that a large provider of services collapses or is otherwise unable to provide needed services and shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.8.2.

41. Section 2.12.9.15 shall be amended by adding a new sentence to the end of the existing text as follows:

2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees and providers shall give TENNCARE or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ. Said records are to be provided by the provider at no cost to the requesting agency;

42. Section 2.12 shall be amended by adding a new Section 2.12.15 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.12.15 The CONTRACTOR shall maintain an agreement with the PBM for the purpose of making payment to the PBM on behalf of TENNCARE for TennCare covered services. The agreement shall be in accordance with an approved template provided by TENNCARE. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section 3).

43. Section 2.13 shall be amended by adding a new Section 2.13.9 as follows and reunumbering the remaining Sections accordingly, including any refereces thereto.

2.13.9 Payment to TennCare PBM

2.13.9.1 The CONTRACTOR shall make payment to the PBM on behalf of TENNCARE for TennCare covered services. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section 3). The CONTRACTOR shall adhere to the following process for payments to the PBM:

2.13.9.1.1 The CONTRACTOR shall maintain a separate bank account for the funds transfer from TENNCARE for purposes of payment to the PBM.

2.13.9.1.2 The CONTRACTOR shall receive a weekly invoice from the PBM for services rendered by the PBM.

2.13.9.1.3 The CONTRACTOR shall invoice TENNCARE for the cost of the payments to be made to the PBM based on the weekly PBM invoice as well as any associated regulatory costs.

2.13.9.1.4 The CONTRACTOR shall make payment to the PBM in the full amount of the funds transfer from TENNCARE no later than the Friday following reciept of the funds from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays.

44. Section 2.15.1.1 shall be deleted and replaced as follows:

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

45. Section 2.15.2.1 shall be amended by adding the words ", annual evaluation" in the last sentence as follows:

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description, annual evaluation

and associated work plan prior to submission to TENNCARE as required in Section 2.30.12.1, Reporting Requirements.

46. Section 2.17.1.1 shall be deleted and replaced as follows:

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials). Should the CONTRACTOR decide to contract with either a subcontractor or its providers to create and/or distribute member materials, the materials shall not be distributed to members unless the materials have been submitted to TENNCARE by the CONTRACTOR for review and prior written approval. Member Materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

47. Section 2.17.2 shall be amended by adding a new Section 2.17.2.3 and renumbering the remaining Section 2.17.2 as follows, including any reference thereto.

2.17.2.3 Articles and/or informational material included in written materials such as newsletters, brochures, etc. shall be limited to approximately 200 words for purposes of readability unless otherwise approved in writing by TENNCARE;

48. Section 2.17.4.7.18 shall be deleted and replaced as follows:

2.17.4.7.18 Shall include notice of the right to file a discrimination complaint as provided for by applicable federal and state civil rights laws, including but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990, and a complaint form on which to do so. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;

49. Section 2.17.5.3.5 shall be deleted and replaced as follows:

2.17.5.3.5 A notice of the right to file a discrimination complaint, as provided for by applicable federal and state civil rights laws, including, but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990 and a complaint form on which to do so. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;

50. Section 2.18.1.3 shall be deleted and replaced as follows:

2.18.1.3 The member services information line shall handle calls from individuals with LEP and individuals with disabilities, including, but not limited to individuals with hearing and/or speech disabilities.

51. Sections 2.20.1.7 through 2.20.1.7.3 shall be deleted and replaced as follows:

2.20.1.7 The CONTRACTOR is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

2.20.1.7.1 The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or

2.20.1.7.2 The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or

2.20.1.7.3 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee, are the subject of pending Federal or State litigation or investigation, or are being audited by the TennCare RAC.

52. Section 2.21.6.1.4 shall be deleted and replaced as follows:

2.21.6.1.4 Except for those payments described in Section 3.15, any and all payments made by TENNCARE, including capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-112.

53. Section 2.23.5.2 shall be amended by adding a new sentence to the end of the existing text as follows:

2.23.5.2 The CONTRACTOR shall systematically update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

54. Section 2.24.4.1 shall be amended by adding the phrase "on at least an annual basis" after the phrase "and a plan for training" as follows:

2.24.4.1 The CONTRACTOR shall develop and implement an abuse and neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of CHOICES members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of CHOICES members who are children (see TCA 37-1-401 *et seq.* and TCA 37-1-601 *et seq.*); a plan for educating and training providers, subcontractors, care coordinators, and other CONTRACTOR staff regarding the protocols; and a plan for training on at least an annual basis members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect.

55. Section 2.27 shall be amended by adding new Sections 2.27.9 and 2.27.10 as follows:

2.27.9 Medicaid and CHIP – Verification of Income and Eligibility. The CONTRACTOR must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan:

2.27.9.1 Purposes directly related to the administration of Medicaid and CHIP include:

2.27.9.1.1 Establishing eligibility;

2.27.9.1.2 Determining the amount of medical assistance;

2.27.9.1.3 Providing services for beneficiaries; and

2.27.9.1.4 Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid or CHIP administration.

2.27.9.2 The CONTRACTOR must have adequate safeguards to assure that:

2.27.9.2.1 Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information received under 26 USC § 6103(l) is exchanged only with parties authorized to receive that information under that section of the Code; and

2.27.9.2.2 The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

2.27.9.3 The CONTRACTOR must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least:

2.27.9.3.1 Names and addresses;

2.27.9.3.2 Medical services provided;

2.27.9.3.3 Social and economic conditions or circumstances;

2.27.9.3.4 CONTRACTOR evaluation of personal information;

2.27.9.3.5 Medical data, including diagnosis and past history of disease or disability;

2.27.9.3.6 Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service;

2.27.9.3.7 Any information received for verifying income eligibility and amount of medical assistance payments;

2.27.9.3.8 Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements;

2.27.9.3.9 Any information received in connection with the identification of legally liable third party resources; and

2.27.9.3.10 Social Security Numbers.

2.27.9.4 The CONTRACTOR must have criteria approved by the State specifying:

2.27.9.4.1 The conditions for release and use of information about applicants and beneficiaries;

2.27.9.4.2 Access to information concerning applicants or beneficiaries must be restricted to persons or CONTRACTOR representatives who are subject to standards of confidentiality that are comparable to those of the State;

2.27.9.4.3 The CONTRACTOR shall not publish names of applicants or beneficiaries;

2.27.9.4.4 The CONTRACTOR shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;

2.27.9.4.5 If, because of an emergency situation, time does not permit obtaining consent before release, the CONTRACTOR shall notify the State, the family or individual immediately after supplying the information;

2.27.9.4.6 The CONTRACTOR's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials;

2.27.9.4.6.1 The CONTRACTOR shall notify the State of any requests for information on applicants or beneficiaries by other governmental bodies, the courts or law enforcement officials ten (10) days prior to releasing the requested information.

2.27.9.4.7 If a court issues a subpoena for a case record or for any CONTRACTOR representative to testify concerning an applicant or beneficiary, the CONTRACTOR must notify the State at least ten (10) days prior to the required production date so the State may inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014; and

2.27.9.4.8 The CONTRACTOR shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from the State.

2.27.10 Social Security Administration (SSA) Required Provisions for Data Security. The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.

2.27.10.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Agreement for any purpose other than that set forth in this Agreement for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

2.27.10.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Agreement.

2.27.10.3 The CONTRACTOR shall provide a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE.

2.27.10.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Agreement. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.

2.27.10.5 The CONTRACTOR shall ensure that its employees:

2.27.10.5.1 Properly safeguard PHI/PII furnished by TENNCARE under this Agreement from loss, theft or inadvertent disclosure;

2.27.10.5.2 Understand that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;

2.27.10.5.3 Ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;

2.27.10.5.4 Send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and

2.27.10.5.5 Limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

2.27.10. 6 CONTRACTOR employees who access, use, or disclose TENNCARE or TennCare SSA supplied data in a manner or purpose not authorized by this Agreement may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

2.27.10. 7 Loss or Suspected Loss of Data -- If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, the appropriate designee of the CONTRACTOR must immediately contact TENNCARE upon becoming aware to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://www.ab.gov/forms/land/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.

2.27.10.7.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.

2.27.10.8 TENNCARE may immediately and unilaterally suspend the data flow under this Agreement, or terminate this Agreement, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Agreement.

2.27.10. 9 In order to meet certain requirements set forth in the State's Computer Matching and Privacy Protection Act Agreement (CMPPA) with the SSA, the Parties acknowledge that this Section shall be included in all agreements executed by or on behalf of the State. The Parties further agree that FISMA and NIST do not apply in the context of data use and disclosure under this Agreement as the Parties shall neither use nor operate a federal information system on behalf of a federal executive agency. Further, NIST is applicable to federal information systems; therefore, although encouraged to do so, the State, its CONTRACTORs, agents and providers are not required to abide by the NIST guidelines.

2.27.10.10 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the SSA stipulates that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.

2.27.10.11 Definitions

2.27.10.11.1 "SSA-supplied data" -- information, such as an individual's social security number, supplied by the Social Security Administration to TENNCARE to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TENNCARE).

2.27.10.11.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

2.27.10.11.3 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care

clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2.27.10.11.4 "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

56. Section 2.29.1.3.9 shall be deleted and replaced as follows:

2.29.1.3.9 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for the CONTRACTOR's compliance with applicable federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-discrimination Compliance, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

57. Section 2.30.3 shall be deleted and replaced as follows:

2.30.3 **Community Outreach**

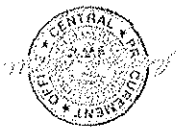
2.30.3.1 The CONTRACTOR shall submit an *Annual Community Outreach Plan* no later than November 30 of each year for review and approval by TENNCARE. The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; community/health education events unrelated to TENNderCare; and a process for evaluating the benefits of the events.

2.30.3.2 The CONTRACTOR shall submit an *Annual Community Outreach Evaluation,* in a format specified by TENNCARE, of its approved Annual Community Outreach Plan no later than ninety (90) days following the end of a calendar year.

58. Sections 2.30.6.5 and 2.30.6.6 shall be amended by deleting the references to "homemaker" and "homemaker services".

59. Section 2.30.8.2 shall be deleted and replaced as follows:

2.30.8.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access



standards as well as an emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. This report/plan shall also be available upon request. (See Section 2.11.1.10.)

60. Section 3.10 shall be deleted and replaced as follows:

3.10 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

3.10.1 General

3.10.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 3.10.

3.10.1.2 Pursuant to 42 CFR 438.6, the total of all payments made to the CONTRACTOR for a year shall not exceed one hundred and five percent (105%) of capitation payments made to the CONTRACTOR.

3.10.1.3 In the first year that the incentives specified in Sections 3.10.2 are available, the TennCare regional average HEDIS score (as calculated by TENNCARE using audited MCO HEDIS results) for each of the measures specified in Sections 3.10.2 for the last full calendar year prior to the year that the CONTRACTOR began operating under this Agreement will serve as the baseline. If complete TennCare HEDIS data for these measures is not available for the region for the year prior to the year that the CONTRACTOR began operating under this Agreement, then the last year for which complete data is available will serve as the baseline.

3.10.1.4 Beginning on July 1, 2015, the CONTRACTOR shall be eligible for incentives in accordance with Section 3.10.4 below and the incentives described in Sections 3.10.2 and 3.10.3 shall no longer apply.

3.10.1.5 If NCQA makes changes in any of the measures selected by TENNCARE, such that valid comparison to prior years will not be possible, TENNCARE, at its sole discretion, may elect to either eliminate the measure from pay-for-performance incentive eligibility or replace it with another measure.

3.10.2 Physical Health HEDIS Measures

3.10.2.1 Beginning on July 1, 2010, on July 1 of each year through July 1, 2014, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 3.10.2.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR's HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below).

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

3.10.2.2.1 HbA1C Testing – Diabetes measure;

3.10.2.2.2 HbA1C Control – Diabetes measure;

3.10.2.2.3 LDL-C Screening Performed – Diabetes measure;

3.10.2.2.4 Adolescent Well-Care Visits;

3.10.2.2.5 Breast Cancer Screening; and

3.10.2.2.6 Controlling High Blood Pressure.

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

3.10.3 **Behavioral Health HEDIS Measures**

3.10.3.1 Beginning on July 1, 2010, on July 1 of each year through July 1, 2014, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR's HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. To be eligible for incentive payment for a measure, the CONTRACTOR must demonstrate significant improvement for both rates comprising the measure. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below).

3.10.3.2 Audited HEDIS Measures:

3.10.3.2.1 Antidepressant Medication Management;

3.10.3.2.2 Follow-up Care for Children Prescribed ADHD Medication; and

3.10.3.2.3 Follow-Up After Hospitalization for Mental Illness.

3.10.4 **HEDIS Measures (Beginning July 1, 2015)**

3.10.4.1 On July 1 of each year, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures in accordance with Section 3.10.4.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below).

3.10.4.2 Incentive payments will be available for selected audited HEDIS measures as determined by TENNCARE following review and analysis of HEDIS plan-specific rates.

3.10.4.2.1 Beginning calendar year 2014, in August of each year TENNCARE will notify the CONTRACTOR of the audited HEDIS measures that have been selected for eligibility for the following calendar year's Pay-For-Performance Quality Incentive Measures in each region for which the CONTRACTOR serves.

3.10.4.2.2 The annual notification will advise the CONTRACTOR of the specifics that TENNCARE will use to determine eligibility for the Pay-For-Performance Quality Incentive Payments.

3.10.5 **NCQA Minimum Effect Size Change Methodology**

The NCQA minimum effect size change methodology is as follows:

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

61. Sections 3.11.3 through 3.11.5 shall be deleted and replaced as follows:

3.11.3 MFP incentive payments pertaining to benchmark #1 shall be payable within sixty (60) days following the end of each calendar quarter for activities performed during the quarter.

3.11.4 The MFP incentive payments pertaining to benchmark #s 3-5 (which shall depend on the total number of these benchmarks which the CONTRACTOR meets or exceeds) shall be payable within sixty (60) days following the end of each calendar year for activities performed during the year.

3.11.5 Any additional MFP incentive payment pertaining to achievement of benchmark #2, which shall reflect the difference between the total incentive payment due the CONTRACTOR for benchmarks #s 2-5 and the incentive payment already made in Section 3.11.4 above (see Section 3.11.2), shall be due by August 31following the close of the calendar year to permit adequate time for any lag in claims and encounter submission.

62. Section 3.13 shall be amended by adding the phrase "for all payments received under this Agreement" as follows:

3.13 HMO PAYMENT TAX

The CONTRACTOR shall be responsible for payment of applicable taxes for all payments received under this Agreement pursuant to TCA 56-32-124. In the event the amount due pursuant to TCA 56-32-124 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

63. Section 3 shall be amended by adding a new Section 3.15 as follows and renumbering the remaining Section accordingly, including any references thereto.

3.15 PAYMENT FOR DISTRIBUTION TO TENNCARE'S PBM

3.15.1 TENNCARE shall make a payment to the CONTRACTOR in an amount equal to the invoice that is billed to the CONTRACTOR by the TennCare PBM. The CONTRACTOR shall make payment to the TennCare PBM no later than the Friday following reciept of the payment from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays. This payment is not considered a part of the CONTRACTOR's capitation payment and shall not be subject to the withhold described in Section 3.9 of this Agreement.

64. Section 4.3.10 shall be deleted and replaced as follows:

4.3.10 42 U.S.C. § 18116.

65. The Program Issue in Level A.17 of Section 4.20.2.2.7 shall be amended by deleting "homemaker,".

66. The Program Issue in Level B.21 of Section 4.20.2.2.7 shall be amended by adding the following references: "2.9.6.2.3.4(4), 2.9.6.5.1.1, 2.9.6.9.2.1.2, 2.9.6.9.3, and 2.24.4.2.1.

67. Attachment III shall be amended by deleting and replacing the last bullet point before the final 2 paragraphs as follows:

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

68. Attachment V shall be amended by deleting and replacing the Geographic Access Requirement for Psychiatric Inpatient Hospital Services as follows:

Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)

69. Attachment VIII shall be amended by deleting and replacing Item 106, adding a new 107 as follows and renumbering the remaining Items accordingly.

106. Annual Community Outreach Plan (see Section 2.30.3.1)

107. Annual Community Outreach Evaluation (see Section 2.30.3.2)

70. **Section A.5.5.1 of Attachment XI shall be deleted and replaced as follows:**

A.5.5.1 The CONTRACTOR shall provide a trip manifest to the NEMT provider of all new trips requested no later than four (4) business days before the date of the NEMT service.

71. **Section 2.12.9 shall be amended by adding a new Section 2.12.9.60 and renumbering the remaining Section accordingly, including any references thereto.**

2.12.9.60 Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;

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 June 1, 2013.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Agreement, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____ 6/10/13
Mark Emkes
Commissioner

DATE: 5/31/2013

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY: _____ 6/7/13
Scott A. Bowers
Chief Executive Officer, TennCare

DATE: 05/01/13

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
Brian Kelsey
Steve Southerland
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*
Reginald Tate
Ken Yager

Rep. Mark White, Vice-Chairman
Representatives
Charles Curtiss
Jeremy Faison
Brenda Gilmore
Matthew Hill
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*
Pat Marsh
Mark Pody
David Shepard
Tim Wirgua

MEMORANDUM

TO: Jessica Robertson, Chief Procurement Officer
Department of General Services

FROM: Senator Bill Ketron, Chairman BK
Representative Mark White, Vice-Chairman MW

DATE: February 5, 2013

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 2/4/13)

RFS# 318.66-051 (Edison # 29634)
Department: Finance and Administration
Division: Health Care Finance and Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment adds language requested by CMS regarding the Primary Care Rate Bump Final Rule as required by the Affordable Care Act.
Current maximum liability: $6,313,567,211
Proposed maximum liability: $6,313,567,211

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

cc: The Honorable Darin Gordon, Deputy Commissioner

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

January 9, 2013

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Department of Finance and Administration
Division of Health Care Finance and Administration (HCFA) Contract Amendments (7)

Dear Mr. Geise:

The Department of Finance and Administration, Division of Health Care Finance and Administration, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments. The MCO contracts provide medical and behavioral health services to TennCare enrollees. The proposed amendment adds language requested by the Center for Medicare and Medicaid Services (CMS) regarding the Primary Care Rate Bump Final Rule as required by the Affordable Care Act. This added language better reflects the requirements set forth in 42 CFR and the Final Rule as published by CMS.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-31
AMERIGROUP Tennessee, Inc.	FA-07-16936-14
UnitedHealthCare Plan of the River Valley, Inc.	FA-07-16937-14
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-11
Volunteer State Health Plan (West Region)	FA-08-24978-11
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-11
Volunteer State Health Plan (East Region)	FA-08-24983-11

The Department of Finance and Administration, Division of Health Care Finance and Administration, appreciates consideration of these amendments by the Fiscal Review Committee and respectfully requests approval.

Sincerely,

Casey Dungan
Chief Financial Officer

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	29634	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	14
Proposed Amendment Effective Date: *(if applicable)*	March 15, 2013
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	January 11, 2013
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$6,313,567,211.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00
FY: 2013					
$989,205,835.00					

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$848,507,847.90
FY: 2013					
$469,150,682.58					

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.

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:	$2,067,717,045.00	Federal:	$4,245,850,166.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.

Supplemental Documentation Required for Fiscal Review Committee

Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.
Amendment #10 – January 1, 2012	Program Integrity Updates, HIPAA/HITECH clarifications; CHOICES updates; Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; Increase funding to support the services for this contract for FY '12 and FY '13 based on actual expenditures
Amendment #11 – March 1, 2012	Added language to clarify that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility.
Amendment #12 – July 1, 2012	Added requirements for the Contractor regarding the implementation and operation of CHOICES Group 3, language to clarify that QM/QI reporting must be specific to TennCare and not combined with other state or commercial programs, Program Integrity language to clarify PI Investigators be designated by plan, SSA Data Security language added in accordance with our agreement with SSA, and Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. No additional funding is required relative to this amendment.
Amendment #13 – January 1, 2013	(1) Replaces Disease Management requirements with Population Health requirements; (2) Clarification regarding the implementation of CHOICES 3 requirements; (3) Clarification language as requested by CMS regarding TPL and PETI; (4) Include requirement to support CMS require PCP rate increase for 2013/2014; (5) Include requirement to participate and implement initiatives to capture Prenatal and Postnatal visit data; (6) Coordination requirements for MCOs regarding DSNPs; (7) Updates the transportation requirements to reflect current reporting needs and support audit efforts, and (8) provides contract funding for FY '14.

Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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).

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.

Supplemental Documentation Required for Fiscal Review Committee

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.

CONTRACT SUMMARY SHEET

021406

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-13

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
TOTAL:	$ 2,067,717,045.00	$ 4,245,850,166.00	$ -	$ -	**$ 6,313,567,211.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ -	$ 989,205,835.00
TOTAL:	**$ 5,324,361,376.00**	**$ 989,205,835.00**
End Date	December 31, 2014	December 31, 2014

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix: FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg.ID,GG,GU) [ ] Other

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

UnitedHealthCare Plan (Americhoice) - Middle

FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL **$1,051,885,932.05**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2012

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00357932	0000021799	80,164,116.78	8/1/2011
31865	00357935	0000021799	1,749.12	8/1/2011
31865	00373132	0000021799	66,259,994.41	9/2/2011
31865	00373135	0000021799	4,290.68	9/2/2011
			146,430,150.99	
31865	00390204	0000021799	68,500,422.24	10/7/2011
31865	00390207	0000021799	1,970.72	10/7/2011
31865	00396234	0000021799	16,338,030.88	10/17/2011
31865	00396235	0000021799	189,155.42	10/17/2011
31865	00404008	0000021799	77,882,668.64	11/4/2011
31865	00404011	0000021799	1,159.98	11/4/2011
31865	00417176	0000021799	66,848,857.76	12/5/2011
31865	00417179	0000021799	37.42	12/5/2011
			229,762,303.06	
31865	101519377	0000021799	76,652,274.04	1/6/2012
31865	101547443	0000021799	84,528,169.47	2/3/2012
31865	101574349	0000021799	78,374,720.09	3/2/2012
31865	101538873	0000021799	12,350.00	2/1/2012
			239,567,513.60	
31865	101608051	0000021799	77,495,120.45	4/5/2012
31865	101621414	0000021799	1,300.00	4/23/2012
31865	101628167	0000021799	12,000.00	4/27/2012
31865	101635082	0000021799	79,019,045.16	5/4/2012
31865	101662448	0000021799	76,220,414.64	6/1/2012
			232,747,880.25	

FY 2012 TOTAL $ 848,507,847.90

UnitedHealthCare Plan (Americhoice) - Middle

FY 2013

Unit	Voucher ID	Vendor ID		Amount Pd	Pymnt Date
31865	101696065	0000021799	$	77,600,771.38	7/6/2012
31865	101723402	0000021799	$	79,380,930.51	8/3/2012
31865	101758287	0000021799	$	77,957,765.92	9/7/2012
				234,939,467.81	
31865	00583536	0000021799		77,555,656.30	10/5/2012
31865	00590779	0000021799		44,000.00	10/19/2012
31865	00598074	0000021799		78,885,213.03	11/2/2012
31865	00615111	0000021799		77,726,345.44	12/7/2012
				234,211,214.77	

FY 2013 TOTAL $ **469,150,682.58**

129. Attachment XII shall be amended by deleting and replacing EXHIBIT G and adding a new EXHIBIT H as follows:

EXHIBIT G
CAPITATION RATES
MIDDLE
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 580.21
	Age 1 - 13	$ 96.79
	Age 14 - 20 Female	$ 237.27
	Age 14 - 20 Male	$ 144.69
	Age 21 - 44 Female	$ 399.51
	Age 21 - 44 Male	$ 251.34
	Age 45 – 64	$ 418.83
	Age 65 +	$ 484.02
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 87.13
	Age 14 - 19 Female	$ 121.42
	Age 14 – 19 Male	$ 127.39
Disabled	Age < 21	$ 1,374.26
	Age 21 +	$ 996.91
Duals/Waiver Duals	All Ages	$ 218.65
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

EXHIBIT H
CAPITATION RATES
MIDDLE
UnitedHealthCare
EFFECTIVE January 1, 2012

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 578.51
	Age 1 - 13	$ 96.35
	Age 14 - 20 Female	$ 235.93
	Age 14 - 20 Male	$ 143.93
	Age 21 - 44 Female	$ 397.23
	Age 21 - 44 Male	$ 250.00
	Age 45 – 64	$ 416.37
	Age 65 +	$ 482.23
Uninsured/Uninsurable	Age Under 1	$ 578.03
	Age 1 - 13	$ 86.69
	Age 14 - 19 Female	$ 120.59
	Age 14 – 19 Male	$ 126.84
Disabled	Age < 21	$ 1,365.38
	Age 21 +	$ 990.79
Duals/Waiver Duals	All Ages	$ 215.96
CHOICES Rate	CHOICES Duals	$ 3,991.51
	CHOICES Non-Duals	$ 5,578.98

78. Attachment VI shall be amended by deleting the performance standard for Non-IMD Inpatient Use in its entirety.

79. Attachment IX, Exhibit I shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

80. The first two populations listed in Attachment IX, Exhibit K shall be deleted and replaced as follows:

- Medicaid (Child and Adult)
- Uninsured (Child and Adult)

81. Item 14 of Exhibit A of Attachment XI shall be deleted and replaced as follows:

14. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with mental retardation. DIDD is a division of the Tennessee Department of Finance and Administration.

82. Attachment XII shall be amended by adding a new Exhibit G as follows:

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 – 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

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

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

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

ATTACHMENT X

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

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

125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".

126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".

127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

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

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

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED
CENTRAL PROCUREMENT OFFICE

Request Tracking #	**31866-00051**
Procuring Agency	**Department of Finance and Administration Bureau of TennCare**
Contractor	**UnitedHealthCare Plan of the River Valley, Inc.**
Contract #	**FA-07-16937-00**
Proposed Amendment #	**14**
Edison ID #	**29634**

Contract Begin Date	**August 15, 2006**
Current Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Proposed Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Current Maximum Contract Cost *– with ALL options to extend exercised*	**$6,313,567,211.00**
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	**$6,313,567,211.00**
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	**X Not Applicable** ☐ **Attached**
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	**X Not Applicable** ☐ **Attached**
Human Resources Support *– state employee training service*	**X Not Applicable** ☐ **Attached**

Explanation Need for the Proposed Amendment

This competitively procured contract provides medical and behavioral health services to TennCare enrollees. The proposed amendment adds language requested by the Center for Medicare and Medicaid Services (CMS) regarding the Primary Care Rate Bump Final Rule as required by the Affordable Care Act. This added language better reflects these requirements set forth in 42 CFR and the Final Rule as published by CMS.

Request Tracking #	31866-00051

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to provide language requested by the Center for Medicare and Medicaid Services (CMS) regarding the Primary Care Rate Bump Final Rule as required by the Affordable Care Act. This added language better reflects the requirements set forth in 42 CFR and the Final Rule as published by CMS. The Bureau of TennCare respectfully requests review and approval of this contract amendment.

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark C. Ember 1/7/13

CONTRACT SUMMARY SHEET

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-14

State Agency	State Agency Division
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
TOTAL:	$ 2,067,717,045.00	$ 4,245,850,166.00	$ -	$ -	$ 6,313,567,211.00

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ 989,205,835.00	
TOTAL:	$ 6,313,567,211.00	$ -
End Date	December 31, 2014	

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg.ID,GG,GU) [ ] Other

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

AMENDMENT NUMBER 14
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and NAME, 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 2.13.8 shall be deleted and replaced as follows:

2.13.8 **Medicaid Payment for Primary Care**

2.13.8.1 In accordance with the Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act), for calendar years 2013 and 2014, the CONTRACTOR shall make payments for certain primary care services (as described by CMS) and furnished by primary care providers (as described by CMS) in an amount that has been determined by CMS. Payments and reporting as required by this Section 2.13.8 shall be effective for dates of service beginning January 1, 2013. Should retroactive payments be necessary due to the timing of the implementation of this requirement, the CONTRACTOR shall make adjustments to previously paid claims for the enhanced payment to eligible primary care providers without any effort from the provider.

2.13.8.2 In addition to the routine claims payment reports required by this Agreement, the CONTRACTOR shall report to TENNCARE any information related to this requirement in a format described by TENNCARE. At a minimum, the reports shall be sufficient to accomplish the following:

2.13.8.2.1 Submit 2009 payment data on primary care services which qualify for payment under this rule;

2.13.8.2.2 Assure payments made to specified primary care providers are at the minimum Medicare primary care payment levels as required by 42 CFR 447, subpart G. This includes the assurance that eligible providers receive direct and full benefit of the payment increase for each of the primary care services specified in the final rule implementing this section of The Affordable Care Act regardless of whether the provider is paid directly or through a capitated arrangement;

2.13.8.2.3 Submit any documentation to TENNCARE, sufficient to enable TENNCARE and CMS to ensure that provider payments increase as required by 42 CFR 438.6(c)(5)(vi)(A) are made and to adequately document expenditures eligible for 100% FFP and to support all audit or reconciliation processes. TENNCARE shall report these data to CMS.

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 March 15, 2013.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A Emkes /cp
Mark Emkes
Commissioner

DATE: 2/14/2013

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY:
Scott A. Bowers
Chief Executive Officer, TennCare

DATE: 02/11/13

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
Brian Kelsey, Ken Yager
Eric Stewart
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Curtis Johnson, Vice-Chairman
Representatives
Tommie Brown, David Shepard
Jim Coley, Tony Shipley
Charles Curtiss, Curry Todd
Johnny Shaw, Mark White
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

TO: Jessica Robertson, Chief Procurement Officer
Department of General Services

FROM: Senator Bill Ketron, Chairman BK
Representative Curtis Johnson, Vice-Chairman CJ

DATE: November 27, 2012

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 11/26/12)

RFS# 318.66-051 (Edison # 29634)
Department: Finance and Administration
Division: Health Care Finance and Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment provides critical updates and clarifications to ensure optimal performance; updates capitation rates; and increases maximum liability by $989,205,835.
Current maximum liability: $5,324,361,376
Proposed maximum liability: $6,313,567,211

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

cc: The Honorable Darin Gordon, Deputy Commissioner

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

October 31, 2012

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Department of Finance and Administration
Division of Health Care Finance and Administration (HCFA)
Contract Amendments (12)

Dear Mr. Geise:

The Department of Finance and Administration, Division of Health Care Finance and Administration, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments. The MCO contracts provide medical and behavioral health services to TennCare enrollees. The proposed amendments provide the following updates: (1) Replaces Disease Management requirements with Population Health requirements; (2) Clarification regarding the implementation of CHOICES 3 requirements; (3) Clarification language as requested by CMS regarding TPL and PETI; (4) Includes requirement to support CMS required PCP rate increase for 2013/2014; (5) Includes requirement to participate in and implement initiatives to capture Pre-natal and Post-natal visit data; (6) Coordination requirements for MCOs regarding DSNPs; (7) Updates the transportation requirements to reflect current reporting needs and support audit efforts; (8) Updates contract to include current capitation rates, (9) extends contract term for East/West Regions and VSHP Select, and (10) provides funding for FY '14.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-30
AMERIGROUP Tennessee, Inc.	FA-07-16936-13
UnitedHealthCare Plan of the River Valley, Inc.	FA-07-16937-13
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-10
Volunteer State Health Plan (West Region)	FA-08-24978-10
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-09
Volunteer State Health Plan (East Region)	FA-08-24983-09

Additionally, we are submitting for consideration amendment #1 to the existing competitively procured contract with QSource, the competitively procured contractor for the provision of TennCare's External Quality Review. This amendment, pursuant to RFP and contract language, provides for term extension and extension funding based on competitive rates submitted in the Cost Proposal. Additional CHOICES scope of work and monthly rates are being added to the contract to provide an annual CHOICES survey and corresponding written evaluations regarding CHOICES member participation and satisfaction.

The following contract amendments are being submitted for the HCFA Cover Tennessee Program for contract amendments that extend the term for the final year and provide funding to support the continuation of services.

Policy Studies, Inc.	FA-07-20295-08
National Guardian Life Insurance Company	FA-08-23921-03
BlueCross Blue Shield of Tennessee, Inc.	FA-12-37367-01
QSource	FA-10-30464-02

The Department of Finance and Administration, Division of Health Care Finance and Administration, would greatly appreciate the consideration and approval of these amendments by the Fiscal Review Committee.

Sincerely,

Casey Dungan
Chief Financial Officer

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	29634	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	13
Proposed Amendment Effective Date: *(if applicable)*	January 1, 2013
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	October 31, 2012
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$5,324,361,376.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00
FY: 2013					
$989,205,835.00					

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$848,507,847.90
FY: 2013					
$234,939,467.81					

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.

Supplemental Documentation Required for Fiscal Review Committee

IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	N/A			
*Contract Funding Source/Amount:	State:	$1,726,441,032.00	Federal:	$3,597,920,344.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.

Supplemental Documentation Required for Fiscal Review Committee

Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.
Amendment #10 – January 1, 2012	Program Integrity Updates, HIPAA/HITECH clarifications; CHOICES updates; Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; Increase funding to support the services for this contract for FY '12 and FY '13 based on actual expenditures
Amendment #11 – March 1, 2012	Added language to clarify that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility.
Amendment #12 – July 1, 2012	Added requirements for the Contractor regarding the implementation and operation of CHOICES Group 3, language to clarify that QM/QI reporting must be specific to TennCare and not combined with other state or commercial programs, Program Integrity language to clarify PI Investigators be designated by plan, SSA Data Security language added in accordance with our agreement with SSA, and Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. No additional funding is required relative to this amendment.

Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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).

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.

Supplemental Documentation Required for Fiscal Review Committee

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.

UnitedHealthCare Plan (Americhoice) - Middle

FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL **$1,051,885,932.05**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2012

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00357932	0000021799	80,164,116.78	8/1/2011
31865	00357935	0000021799	1,749.12	8/1/2011
31865	00373132	0000021799	66,259,994.41	9/2/2011
31865	00373135	0000021799	4,290.68	9/2/2011
			146,430,150.99	
31865	00390204	0000021799	68,500,422.24	10/7/2011
31865	00390207	0000021799	1,970.72	10/7/2011
31865	00396234	0000021799	16,338,030.88	10/17/2011
31865	00396235	0000021799	189,155.42	10/17/2011
31865	00404008	0000021799	77,882,668.64	11/4/2011
31865	00404011	0000021799	1,159.98	11/4/2011
31865	00417176	0000021799	66,848,857.76	12/5/2011
31865	00417179	0000021799	37.42	12/5/2011
			229,762,303.06	
31865	101519377	0000021799	76,652,274.04	1/6/2012
31865	101547443	0000021799	84,528,169.47	2/3/2012
31865	101574349	0000021799	78,374,720.09	3/2/2012
31865	101538873	0000021799	12,350.00	2/1/2012
			239,567,513.60	
31865	101608051	0000021799	77,495,120.45	4/5/2012
31865	101621414	0000021799	1,300.00	4/23/2012
31865	101628167	0000021799	12,000.00	4/27/2012
31865	101635082	0000021799	79,019,045.16	5/4/2012
31865	101662448	0000021799	76,220,414.64	6/1/2012
			232,747,880.25	

FY 2012 TOTAL $ 848,507,847.90

UnitedHealthCare Plan (Americhoice) - Middle

FY 2013

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	101696065	0000021799	$ 77,600,771.38	7/6/2012
31865	101723402	0000021799	$ 79,380,930.51	8/3/2012
31865	101758287	0000021799	$ 77,957,765.92	9/7/2012
			234,939,467.81	

FY 2013 TOTAL $ 234,939,467.81

78. Attachment VI shall be amended by deleting the performance standard for Non-IMD Inpatient Use in its entirety.

79. Attachment IX, Exhibit I shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

80. The first two populations listed in Attachment IX, Exhibit K shall be deleted and replaced as follows:

- Medicaid (Child and Adult)
- Uninsured (Child and Adult)

81. Item 14 of Exhibit A of Attachment XI shall be deleted and replaced as follows:

14. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with mental retardation. DIDD is a division of the Tennessee Department of Finance and Administration.

82. Attachment XII shall be amended by adding a new Exhibit G as follows:

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 – 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

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

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

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

ATTACHMENT X

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

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

125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".

126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".

127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

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

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

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED
CENTRAL PROCUREMENT OFFICE

Request Tracking #	**31866-00051**
Procuring Agency	**Department of Finance and Administration Bureau of TennCare**
Contractor	**UnitedHealthCare Plan of the River Valley, Inc.**
Contract #	**FA-07-16937-00**
Proposed Amendment #	**13**
Edison ID #	**29634**

Contract Begin Date	**August 15, 2006**
Current Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Proposed Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Current Maximum Contract Cost *– with ALL options to extend exercised*	**$ 5,324,361,376.00**
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	**$6,313,567,211.00**
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	**X Not Applicable** ☐ **Attached**
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	**X Not Applicable** ☐ **Attached**
Human Resources Support *– state employee training service*	**X Not Applicable** ☐ **Attached**

Explanation Need for the Proposed Amendment

This competitively procured contract provides medical and behavioral health services to TennCare enrollees. The proposed amendment provides the following updates: (1) Replaces Disease Management requirements with Population Health requirements; (2) Clarification regarding the implementation of CHOICES 3 requirements; (3) Clarification language as requested by CMS regarding TPL and PETI; (4) Include requirement to support CMS require PCP rate increase for 2013/2014; (5)

Request Tracking #	31866-00051

Include requirement to participate and implement initiatives to capture Prenatal and Postnatal visit data; (6) Coordination requirements for MCOs regarding DSNPs; (7) Updates the transportation requirements to reflect current reporting needs and support audit efforts, and (8) provides contract funding for FY '13.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to provide requirements for the Contractor regarding the following updates: (1) Replaces Disease Management requirements with Population Health requirements; (2) Clarification regarding the implementation of CHOICES 3 requirements; (3) Clarification language as requested by CMS regarding TPL and PETI; (4) Include requirement to support CMS require PCP rate increase for 2013/2014; (5) Include requirement to participate and implement initiatives to capture Prenatal and Postnatal visit data; (6) Coordination requirements for MCOs regarding DSNPs; (7) Updates the transportation requirements to reflect current reporting needs and support audit efforts, and (8) provides contract funding for FY '13. All of these elements contained in this amendment are required to enhance the medical and behavioral services provided by the Contractor for the benefit of the TennCare population.

Request Tracking #	31866-00051

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark E. Emkes 10/6/12

CD

CONTRACT SUMMARY SHEET

021406

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-13

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
2014	$ 341,276,013.00	$ 647,929,822.00			$ 989,205,835.00
TOTAL:	$ 2,067,717,045.00	$ 4,245,850,166.00	$ -	$ -	**$ 6,313,567,211.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
2014	$ -	$ 989,205,835.00
TOTAL:	**$ 5,324,361,376.00**	**$ 989,205,835.00**
End Date	December 31, 2014	December 31, 2014

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix: FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg,ID,GG,GU) [ ] Other

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

AMENDMENT NUMBER 13
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and NAME, 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 adding the following new definitions:

Advance Determination- A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) that an Applicant would not qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) when enrollment into CHOICES Group 3 has not actually been denied or terminated, and which may impact the person's NF LOC eligibility.

Chronic Condition – as defined by Population Health (and AHRQ) is a condition that lasts 12 months or longer and meets one of both of the following tests: (a) it places limitation on self-care, independent living, and social interactions; (b) it results in the need for ongoing intervention with medical products, services, and special equipment (see Perrin et al., 1993)

Engaged – When a member consents to participate in a Population Health program, the member can be determined to be engaged.

Health Coaching – A method of guiding and motivating members participating in Population Health programs to address their health by engaging in self-care and, if needed, make behavioral changes to improve their health. Health coaching operates on the premise that increasing a member's confidence in managing their health and achieving their own goals will have a more lasting effect on outcomes.

Interactive Intervention (Touch) – As it pertains to Population Health it is a two way interaction in which the member receives self management support or health education by one of the following modes: an interactive mail-based communication (i.e. mail-based support or education requested by the member, communication in the form of a member survey, quiz or assessment of member knowledge gained from reading the communication); an interactive telephone contact; including an interactive voice response (IVR)module; an in person contact; and online contact including contact by an interactive web-based module; live chat and secure e-mail. Interactive contacts do not include completion of a health risk appraisal or contacts made only to make an appointment, leave a message, or acknowledge receipt of materials.

Medical Home – As defined by Population Health and per NCQA, the Medical Home is a model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.

Medical Home Lock-in Project – As referred to in CRA 2.8, the project combines the Patient Centered Medical Home with an incentive program based upon quality care. In this project members will only be allowed to see their assigned PCP or another participating PCP within their group /same TIN, because no other provider will be paid for providing services to them. The providers must agree with the health plan to meet specific annual quality of care metrics in their practice. Member outcomes and utilization patterns will be analyzed by the MCO to assess the effectiveness of the project. The primary care providers that meet all specifications and improve quality of care and member outcomes are rewarded by the health plan.

Medical Necessity - Medical Necessity and Medically Necessary as used in this Agreement shall have the meaning contained in Tenn. Code Ann. 71-5-144 and TennCare Rule 1200-13-16.

Non-Interactive Intervention (Touch) – As it pertains to Population Health it is a one way attempt to interact or communicate with members. There is no confirmation of receipt. This does not include completion of a health appraisal.

Plan of Care – As it pertains to Population Health it is a personalized plan to meet a member's specific needs and contains the following elements: prioritized goals that consider member and care giver needs which are documented; a time frame for re-evaluation; the resources to be utilized; a plan for continuity of care, including transition of care and transfers; and uses a collaborative approach including family participation. The plan of care is built upon the information collected from the health assessment to actively engage the member in developing goals and identifying a course of action to respond to the members' needs. The goals and actions in the plan of care must address medical, social, educational, and other services needed by the member. Providing educational materials alone does not meet the intent of this factor.

Population Health Care Coordination Program – The program addresses acute health needs or risks which need immediate attention. Assistance provided to enrollees is short-term and time limited in nature. Activities may include, but are not limited to, assistance with making appointments, transportation, social services, etc. and should not be confused with activities provided through the CHOICES Care Coordination Program.

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

Area Agency on Aging and Disability (AAAD) – Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

CHOICES At-Risk Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with physical disabilities who (1) meet nursing home financial eligibility for TennCare-reimbursed long term services and supports, (2) meet the nursing facility level of care in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TENNCARE CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in TennCare Rules. The CHOICES At-Risk Demonstration Group is open only between July 1, 2012, through December 31, 2013. Individuals enrolled in the CHOICES At-Risk Demonstration Group as of December 31, 2013, may continue to qualify in this group after December 31, 2013, so long as they

(1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES 3.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

Group 1
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

Group 3
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are "at-risk" for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

Interim Group 3 (open for new enrollment only between July 1, 2012, through December 31, 2013)
Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of CHOICES At-Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth is this agreement regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

Risk Agreement – An agreement signed by a CHOICES Group 2 or 3 member who will receive CHOICES HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the possible consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member's decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.

Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, Population Health) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) – The state agency having the authority to provide care for persons with mental illness, and /or substance abuse needs

Transition Allowance– A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES Group 1 member in order to facilitate transition from a nursing facility to the community when such member will, upon transition to CHOICES Group 2 or Group 3, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

3. Section 2.2 shall be amended by adding a new Section 2.2.3 as follows:

2.2.3 If the CONTRACTOR is part of a health maintenance organization holding company system as defined by TCA 56-11-101(b)(5), the CONTRACTOR agrees to comply with the Insurance Holding Company System Act of 1986 as set forth in TCA 56-11-101 et seq. The CONTRACTOR agrees to comply with the requirements of TCA 56-11-101 et seq. whether the CONTRACTOR is domiciled in Tennessee or is a foreign insurer or health maintenance organization subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to this contained in TCA 56-11-101 et seq.

4. Section 2.4.6.1 shall be deleted and replaced as follows:

2.4.6.1 The CONTRACTOR shall receive, process, and update outbound 834 enrollment files from TENNCARE. Enrollment data shall be updated or uploaded systematically to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.

5. Section 2.4.10 shall be deleted and replaced as follows:

2.4.10 Information Requirements Upon Enrollment

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, an identification card, and information regarding how to access and/or request a general provider directory and/or a CHOICES provider directory. In addition, the CONTRACTOR shall provide CHOICES members with CHOICES member education materials (see Section 2.17.7).

6. Section 2.6.1.2.4 and 2.6.1.2.5 shall be deleted and replaced as follows:

2.6.1.2.4 Each of the CONTRACTOR's Population Health programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section 2.9.6.1.9 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section 2.30.6.1.

7. Section 2.6.5.2.5 shall be deleted and replaced as follows:

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2 or Group 3, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars ($2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items. When the CONTRACTOR elects to provide a Transition Allowance to a member transitioning to CHOICES Group 3, the amount of the Transition Allowance shall be applied to the member's Expenditure Cap.

8. Section 2.6.5.3 shall be amended by adding the phrase "or Group 3" in the last sentence as follows:

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES

HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care for CHOICES Group 2 members pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for CHOICES Group 1 members who are transitioning to CHOICES Group 2 or Group 3, and NEMT for Groups 2 and 3

9. Section 2.6.6.2 shall be amended by deleting and replacing the words "disease management" with "Population Health" as follows:

2.6.6.2 The CONTRACTOR shall not offer or provide any services other than services covered by this Agreement (see Section 2.6.1) or services provided as a cost effective alternative (see Section 2.6.5) of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in Population Health programs.

10. Section 2.7.6.4.7.2 shall be deleted and replaced as follows:

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

11. Section 2.8 shall be deleted and replaced in its entirety as follows:

2.8 POPULATION HEALTH

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate an integrated Population Health Program based upon risk stratification of the CONTRACTOR population. The Population Health Model touches members across the entire care continuum, promoting healthy behaviors and disease self management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices. The CONTRACTOR shall evaluate the entire enrollee population and identify enrollees for specific programs according to risk rather than disease specific categories. This approach shall include the following risk Levels and programs:

2.8.1.1.1 **Risk Level 0: Wellness Program**

2.8.1.1.2 **Risk Level 1: Low Risk Maternity, Health Risk Management** and **Care Coordination** programs; and

2.8.1.1.3 **Risk Level 2: Chronic Care Management, High Risk Pregnancy** and **Complex Case Management** programs

2.8.2 Member Identification /Stratification Strategies

2.8.2.1 The CONTRACTOR shall utilize a combination of predictive modeling utilizing claims data, pharmacy data, and laboratory results, supplemented by referrals, UM data, and/ or health risk assessment results to stratify the member population into the following risk categories:

2.8.2.1.1 **Level 0**- The members eligible to participate at this Level shall be determined by predictive modeling to meet ALL of the following: lack of any identified health risks; lack of any identified chronic conditions [as identified by the Chronic Condition tool created by the Agency for Healthcare Research and Quality's (AHRQ)] HCUP database; no indication of pregnancy; and lack of claims history.

2.8.2.1.2 **Level 1**- All members that do not meet the Level 0 or Level 2 criteria.

2.8.2.1.2.1 All members identified as Level 1, through predicative modeling, and not pregnant are eligible for the **Health Risk Management Program**. At a minimum, the CONTRACTOR shall enroll members with the following chronic diseases: Asthma, Bipolar, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Congestive Heart Disease, Diabetes, Major Depression, and Schizophrenia. The CONTRACTOR shall also provide this program for members they identify with other chronic diseases that are prevalent in a significant number of members, or for members with other chronic diseases utilizing significant health resources in their regional population.

2.8.2.1.2.1.1 The CONTRACTOR shall sub-stratify members identified for the Health Risk Management program into high, medium and low categories based on criteria developed by the CONTRACTOR and reported in the annual program description. The CONTRACTOR shall provide the minimum interventions for each category as outlined in Section 2.8.4.3 of this Agreement.

2.8.2.1.2.2 The CONTRACTOR shall identify members for the Level 1, **Care Coordination Program** through referrals, hospital and ED face sheets, and any other means of identifying members with acute health needs or risks which need immediate attention. Members are identified for Care Coordination because their needs do not meet the requirements for complex case management. Members, who have declined participation in Complex Case Management, may also be enrolled in Care Coordination.

2.8.2.1.3 **Level 2** – Members eligible to participate at this Level shall be determined by predictive modeling identifying the top three percent (3%) of members to be most at risk for adverse health outcomes, and/or by referrals or health risk assessments.

2.8.2.1.3.1 The CONTRACTOR shall identify members for the **Chronic Care Management** Program from those Level 2 members that are not pregnant but have complex chronic conditions with multiple identified health risks and or needs. This may include those members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members may also be identified for Chronic Care Management by referrals and health risk assessments.

2.8.2.1.3.2 The CONTRACTOR shall identify members for **Complex Case Management** from those Level 2 members that are not pregnant and have high risk, unique or complex needs. These may include members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members identified by

utilization reports as high pharmacy user or those members which exceed the ED threshold, as defined by TENNCARE shall be reviewed for need for case management. Members may also be identified for Complex Case Management by referrals and health risk assessments.

2.8.2.1.4 The CONTRACTOR shall systematically stratify newly enrolled members on a monthly basis.

2.8.2.1.5 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population to identify the top 3% as defined in section 2.8.2.1.3 of this agreement at a minimum of quarterly intervals to insure members with increasing health risks and needs are identified for level 2 programs.

2.8.2.1.6 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population at a minimum annually.

2.8.2.2 The CONTRACTOR shall identify **pregnant members** through claims, referrals, and the 834 nightly feed, as well as through any other method identified by health plan.

2.8.2.2.1 The CONTRACTOR will stratify pregnant members into either **low or high risk maternity programs** based on the CONTRACTOR's obstetrical assessment. Pregnant members identified as substance abusers, including tobacco users, or who meet other high risk indicators shall be stratified as high risk. Pregnant members who, through the OB assessment, do not meet high risk needs and members who are identified for high risk maternity but choose not to participate, shall be enrolled in the low risk maternity program.

2.8.3 Member Assessment/Identification

2.8.3.1 At time of enrollment the CONTRACTOR shall make a reasonable attempt to assess the member's health.

2.8.3.2 For the Level 2 Population Health programs with a required Health Risk Assessment (HRA), such HRA shall include screening for mental health and substance abuse, physical health conditions, behavioral health conditions, recommended preventive health status and co-morbid physical and behavioral health conditions.

2.8.3.3 For members considered high risk, the assessment shall include documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators).

2.8.3.4 For the voluntary programs of Chronic Care Management, Complex Case Management, or High Risk Maternity Programs, for members considered to have high health risks, shall include assessing the need for a face to face visit. If needed, such a visit shall be conducted following consent of the member.

2.8.4 Program Content and Minimum Interventions

The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the seven (7) Population Health Programs listed in Section 2.8.1 of this Agreement. Activities, interventions, and education objectives appropriate for members will vary for each program with increasing engagement and intensity as level of risk increases. Each program will have a minimum standard set of interventions and frequency of touches but utilize varying modes of communication to attain the program objective.

2.8.4.1 Wellness program

For all eligible **Level 0** members not pregnant the CONTRACTOR shall provide a **Wellness Program** with the objective of keeping members healthy as long as possible.

2.8.4.1.1 The Wellness Program shall utilize educational materials and or activities that emphasize primary and secondary prevention.

2.8.4.1.2 The CONTRACTOR shall provide to members eligible for the **WELLNESS PROGRAM** the following minimum interventions:

Wellness Program Minimum Interventions	
1.	One non-interactive educational quarterly touch to address the following within one year:
	A. How to be proactive in their health **B.** How to access a primary care provider **C.** Preconception and interconception health, to include Dangers of becoming pregnant while using narcotics **D.** Age and/or gender appropriate wellness preventive health services (e.g., "knowing your numbers") **E.** Assessment of special population needs for gaps in care (e.g., recommended immunizations for *children and adolescents)* **F.** Health promotion strategies (e.g., discouraging tobacco use and/or exposure, weight management, stress management, physical activity, substance abuse prevention) **G.** Healthy nutrition **H.** Other healthy and safe life styles

2.8.4.2 Level 1: Low Risk Maternity Program

The CONTRACTOR shall provide a Level 1 Low Risk Maternity Program for eligible members identified as described in Sections 2.8.2.4 and 2.8.2.5 of this Agreement. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications.

2.8.4.2.1 The CONTRACTOR shall operate its Level 1 Maternity Program using an "Opt Out" methodology. Maternity program services shall be provided to all eligible members unless they specifically ask to be excluded.

2.8.4.2.2 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the Level 2 High Risk Maternity Program.

2.8.4.2.3 The CONTRACTOR shall provide to members eligible for the **LEVEL 1 MATERNITY PROGRAM** the following minimum standard interventions:

Maternity Program Minimum Interventions	
1.	Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section 2.8.4.5.2 of this Agreement.
2.	Prenatal packets (considered the one non-interactive intervention to the member for the duration of the pregnancy) to include at a minimum: **A.** Encouragement to access Text4Baby **B.** Access number to maternity nurse/social worker if member would like to engage in monthly maternity management **C.** Preterm labor education **D.** Breast feeding **E.** Secondhand smoke **F.** Safe sleep **G.** Specific trimester health information **H.** Importance of postpartum visit **I.** Importance of screening for postpartum depression **J.** HUGS information **K.** Inter-conception health, to include dangers of becoming pregnant while using narcotics
3.	Follow up as appropriate to determine the status of a prenatal visit to those members who received an initial assessment but had not scheduled or completed their first prenatal visit.
4.	Follow-up to all eligible members, to assess the status of a post-partum visit appointment and assist them with making their appointment if needed.

2.8.4.3 Health Risk Management Program

For eligible Level 1 members, who are not pregnant, identified as designated in Section 2.8.2.1.2.1 of this Agreement, the CONTRACTOR shall provide **a Health Risk Management** Program designed to empower members to be proactive in their health and support the provider-patient relationship. The interventions provided in this program shall address the program's goal of preventing, reducing or delaying exacerbation and complications of a condition or health risk behavior.

2.8.4.3.1 Health coaching or other interventions for health risk management shall emphasize self management strategies addressing healthy behaviors (i.e. weight management and tobacco cessation), self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers.

2.8.4.3.2 The CONTRACTOR shall develop and operate the "opt out" health risk management program per NCQA standard QI 8 for disease management. Program services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.4.3.3 The CONTRACTOR, through a welcome letter, shall inform members how to access and use services, and how to opt in or out of the program. The welcome letter may be used as the required non-interactive intervention if it includes all the required elements as detailed in Section 2.8.4.3.7 of this Agreement.

2.8.4.3.4 The CONTRACTOR shall provide, to members identified with weight management problems, education and support to address and improve this health risk. At the CONTRACTOR's discretion the CONTRACTOR may also provide, as cost effective alternatives, weight management programs for Level 1 or 2 members identified as overweight or obese.

2.8.4.3.5 The CONTRACTOR shall provide, to members identified as users of tobacco, information on availability of tobacco cessation benefits, support and referrals to available resources such as the Tennessee Tobacco Quitline.

2.8.4.3.6 The CONTRACTOR shall sub-stratify populations within the Health Risk Management Program (low, medium, high) based upon identified risk, life style choices (tobacco or substance use), referrals, and identified needs. Interventions for each subpopulation shall be based on risk level or the identified modifiable health risk behavior.

2.8.4.3.7 The CONTRACTOR shall provide to members, who are not participating in a Medical home Lock-in project, in the lowest risk level of the Health Risk Management Program the following minimum standard interventions:

	Health Risk Management Program: **Lowest Risk Level** Minimum Interventions
1.	One documented non-interactive communication each year. The communication shall address self management education emphasizing the following: A. Increasing the members knowledge of their chronic condition B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of their condition E. Self efficacy & support
2.	Offering of individual support for self management if member desires to become engaged.
3.	Availability of 24/7 nurse line.
4.	Availability of health coaching
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5 of this Agreement.

2.8.4.3.8 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, in the medium risk level within the Health Risk Management Program the following minimum standard interventions:

	Health Risk Management Program: **Medium Risk Level** Minimum Interventions
1.	Two documented non-interactive communications each year which shall emphasize self management education addressing the following: A. Members knowledge of their chronic condition B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of their condition E. Self efficacy & support
2.	Offering of interactive communications for self management if need is identified and member desires to become engaged.
3.	Availability of 24/7 nurse line.
4.	Health coaching to provide self management education and support if the need is identified or as requested by eligible members.
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5 of this Agreement.

2.8.4.3.9 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, in the highest risk level within the Health Risk Management Program the following minimum interventions:

	Health Risk Management Program: **Highest Risk Level** Minimum Interventions
1.	Four documented non-interactive communications each year which shall emphasize the following: A. Members knowledge of their chronic condition B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of their condition E. Self efficacy & support
2.	Offering of interactive communications for self management if need is identified and member desires to become engaged which may include; A. Documented action plan as appropriate if the need is identified or are requested by eligible members B. Referrals and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs C. Monitoring and follow up which shall consist of activities and contacts that are necessary to ensure services, appointments and community resources were furnished as planned and shall be appropriately documented for reporting purposes

	D. Defined monitoring for gaps in care
3.	Availability of 24/7 nurse line
4.	Health coaching to provide self management education and support if the need is identified or as requested by eligible members
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5

2.8.4.4 Care Coordination Program

For all eligible members the CONTRACTOR shall provide a Care Coordination Program designed to help non-CHOICES members who may or may not have a chronic disease but have acute health needs or risks that need immediate attention. The goal of the Care coordination program is to assure members get the services they need to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and should not be confused with the CHOICES Care Coordination Program. Services may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. Members receiving care coordination may be those members that were identified for, but declined complex case management

2.8.4.5. Chronic Care Management Program

For all eligible level 2 non-pregnant members the CONTRACTOR shall provide a **Chronic Care Management Program**. The goal of the program is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self management education and support.

2.8.4.5.1 The CONTRACTOR shall develop and operate the "opt in" chronic care management program per NCQA standard QI 8 for disease management.

2.8.4.5.2 The CONTRACTOR shall make three outreach attempts to contact each newly identified member as eligible for Chronic Care Management to offer the member enrollment in the program. All eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but appear on the next refreshed list the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.5.3 Engagement rates for the Chronic Care Management program will be monitored by TENNCARE with baseline determined the first year with improvement from baseline expected in subsequent years. The NCQA Significant Improvement Chart will serve as the measurement of improvement in subsequent years.

2.8.4.5.4 The CONTRACTOR shall conduct a **comprehensive Health Risk Assessment** (HRA) for all members enrolled in the Chronic Care management Program. The HRA should include screening for mental health and substance abuse for all members and screening for physical conditions when member condition is behavioral.

2.8.4.5.5 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, enrolled in the **CHRONIC CARE MANAGEMENT PROGRAM** the following minimum standard interventions:

	Chronic Care Management Program Minimum Interventions
1.	Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of a supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member's condition C. Negotiating with members for appropriate health and behavioral changes D. Problem solving techniques E. The emotional impact of member's condition F. Self efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs H. Regular and sustained monitoring and follow-up
2.	Clinical reminders related to gaps in care.
3.	Suggested elements of the member's plan of care.
4.	Provision of after hour assistance with urgent or emergent needs.

2.8.4.5.6 The CONTRACTOR shall provide ongoing member assessment for the need to move these members into a lower risk classification or to the complex case management program for services.

2.8.4.6 High Risk Maternity

The CONTRACTOR shall provide a **Level 2 High Risk Maternity Program** for eligible members identified as described in Sections 2.8.2.3 and2.8.2.3.1 of this Agreement. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications.

2.8.4.6.1 The CONTRACTOR shall provide screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the attempt protocol referenced in Section 2.8.4.5.1 of this Agreement.

2.8.4.6.2 The CONTRACTOR shall operate its high risk maternity program using an "Opt In" methodology. Program services shall be provided to eligible members that agree to participate in the program.

2.8.4.6.3 The CONTRACTOR shall provide to members enrolled in the **Level 2 HIGH RISK MATERNITY PROGRAM** the following minimum standard interventions:

	High Risk Maternity Program Minimum Interventions
1.	One interactive contact to the member per month of pregnancy to provide intense case management including the following:
	Development of member support relationship by face to face visit or other means as appropriate.
	Monthly interactive contacts to support and follow-up on patient self management. If prenatal visits have not been kept more frequent calls are required.
	Comprehensive HRA to include screening for mental health and substance abuse.
	Development and implementation of individualized care plan.
	Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required.
	Referrals to appropriate community–based resources and follow-up for these referrals.
	If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including TN tobacco Quitline.
2.	Provide prenatal packets including:
	Encouragement to enroll in Text4Baby.
	Encouragement (social marketing) to enroll in High Risk Maternity program.
	Information on preterm labor education.
	Information on breast feeding.
	Information on secondhand smoke.
	Information on safe sleep.
	Trimester specific health information.
	Information on importance of postpartum visit.
	Information on post partum Depression.
	Help Us Grow Successfully (HUGS) TDOH program information.
	Information on inter-conception health, including dangers of Becoming pregnant while using narcotics and long term Contraception.

2.8.4.7 Complex Case Management

The CONTRACTOR shall provide a **Complex Case Management Program** (CCMP) for eligible members, identified by criteria listed in Section 2.8.2 of this Agreement. The goal of the program is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self management support.

2.8.4.7.1 The CONTRACTOR shall offer complex case management to all members identified as eligible. Members will have the right to participate or decline participation.

2.8.4.7.2 The CONTRACTOR shall make three (3) outreach attempts as detailed in Section 2.8.4.5.2 of this agreement.

2.8.4.7.3 The CONTRACTOR shall develop and implement the Complex Case Management Program according to NCQA standard QI 7 for complex case management.

2.8.4.7.4 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment to assess member's needs to include screening for mental health and substance abuse for all members identified with a physical condition and screening for physical conditions when member's condition is behavioral.

2.8.4.7.5 The CONTRACTOR shall provide defined ongoing member assessment for the need to move these members into a lower risk classification or into the Chronic Care Management Program.

2.8.4.7.6 The CONTRACTOR shall provide to members enrolled in the **COMPLEX CASE MANAGEMENT PROGRAM** the following:

Complex Case Management Program Minimum Interventions	
1.	Monthly interactive member contacts to provide individual self management support emphasizing the following:
	One face –to –face visit as deemed appropriate by MCO
	Development of a supportive member and health coach relationship
	Teaching disease specific management skills such as medication adherence and monitoring of the member's condition
	Negotiating with members for appropriate health and behavioral changes
	Providing problem solving techniques
	Assist with the emotional impact of the member's condition
	Self efficacy
	Providing regular and sustained monitoring and follow-up
	Referral and linkages
2.	Providing clinical reminders around HEDIS/gaps in care
3.	Providing after hours assistance with urgent or emergent member needs

2.8.5 Program Description

The CONTRACTOR shall develop and maintain a Population Health **Program Description** addressing all Sections of the CRA and following the guidance documents issued by the Bureau of TennCare, Quality Oversight Division. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk level.

2.8.6 Clinical Practice Guidelines

Population Health programs shall utilize evidence-based clinical practice guidelines that have been formally adopted and updated as described in current NCQA standards. A list of clinical practice guidelines for conditions referenced in Section 2.8.2.1.2.1 of this Agreement, as well as Maternity, Obesity, and Preventive Services must be submitted for review by TENNCARE on an annual basis. For

conditions other than those referenced in this citation policies and procedures established addressing how the health plan assures that information provided to member is based on current best practices.

2.8.7 Informing and educating Members

The CONTRACTOR shall inform all members of the availability of Population Heath Programs and how to access and use the program services. The member shall be provided information regarding their eligibility to participate, how to self refer, and how to either appropriately "opt in" or "opt out" of a program.

2.8.8 Informing and Educating Practitioners

The CONTRACTOR shall educate providers regarding the operation and goals of all Population Health programs. The providers should be given instructions on how to access appropriate services as well as the benefits to the provider. For members receiving interactive interventions, the CONTRACTOR shall notify the practitioners by letter, email, fax, or via a secure web portal of their patient's involvement.

2.8.9 System support and capabilities

The CONTRACTOR shall maintain and operate centralized information system necessary to conduct population health risk stratification. Systems recording program documentation shall meet NCQA Complex Case Management specifications and include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members as needed for follow-up confirmations and to determine intervention outcomes.

2.8.10 CHOICES

The CONTRACTOR shall include CHOICES members **and** dual eligible CHOICES members when risk stratifying its entire population.

2.8.10.2 The CONTRACTOR's Population Health Program description shall describe how the organization integrates a CHOICES member's information with other CONTRACTOR activities, including but not limited to, Utilization Management (UM), Health Risk assessment information, Health Risk Management and Chronic Care Management programs to assure programs are linked and enrollees receive appropriate and timely care.

2.8.10.3 The CONTRACTOR's Population Health Program description shall address how the CONTRACTOR shall ensure that, upon enrollment into CHOICES, Health Risk Management or Chronic Care Management activities are integrated with CHOICES care coordination processes and functions. and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care services, including appropriate management of chronic conditions. If a CHOICES member has one or more chronic conditions, the member's care coordinator may use the CONTRACTOR's applicable Population Health Program's tools and resources, including staff with specialized training, to help manage the member's condition, and shall integrate the use of these tools and resources with care coordination. Population Health staff shall supplement, but not supplant, the role and responsibilities of the member's care coordinator/care coordination team.

2.8.10.4 The CONTRACTOR's program description shall also include the method for addressing the following for CHOICES members:

2.8.10.4.1 Notifying the CHOICES care coordinator of the member's participation in a Population Health Program;

2.8.10.4.2 Providing member information collected to the CHOICES care coordinator.

2.8.10.4.3 Provide to the CHOICES Care Coordinator any educational materials given to the member through these programs;

2.8.10.4.4 Ensure that the care coordinator reviews Population Health educational materials verbally with the member and with the member's caregiver and/or representative (as applicable) and Coordinate follow-up that may be needed regarding the Population Health program, such as scheduling screenings or appointments with the CHOICES Care Coordinator;

2.8.10.4.5 Ensure that the Care Coordinator integrates into the member's plan of care aspects of the Population Health Program that would help to better manage the member's condition; and

2.8.10.4.6 Ensure that the member's care coordinator shall be responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which shall be integrated into the member's plan of care and which shall include monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which will help to better ensure management of the member's condition (see Section 2.9.6 of this Agreement).

2.8.10.5 As part of a Population Health Program, the CONTRACTOR shall place CHOICES members into appropriate programs and/or stratification within a program, not only according to risk Level or other clinical or member-provided information but also 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 targeted interventions for CHOICES members should not only be based on risk level but also based on the setting in which the member resides.

2.8.10.5.1 Targeted methods for informing and educating CHOICES members shall not be limited to mailing educational materials;

2.8.10.6 The CONTRACTOR shall include CHOICES process data in quarterly and annual reports as indicated in Section 2.30.5 of this Agreement. CHOICES members will not be included in outcome measures in annual Population Health reports.

2.8.10.7 The CONTRACTOR shall ensure that upon a member's enrollment in CHOICES, if applicable, all High Risk Population Health Management CONTRACTOR activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's MCO Complex Case Management Program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team.

2.8.10.8 The CONTRACTOR, in addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home, shall provide coordination of care by the CHOICES Care Coordinator and the Population Health Complex Case Management staff:

2.8.10.8.1 The member will be informed by CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;

2.8.10.8.2 Within three (3) business days of a request to transition by or on behalf of a Group 1 member under age 21, the member will be referred by the CHOICES Care Coordinator to MCO Case Management for service identification and implementation in the home setting;

2.8.10.8.3 The Population Health Complex Case Manager will be responsible for developing a service plan for the home setting;

2.8.10.8.4 The CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the Population Health Complex Case Management staff, the member and/or the member's parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until it is determined that the transition is not appropriate or until the plan is complete; and

2.8.10.8.5 Any EPSDT benefits needed by the child in the community as an alternative to nursing facility care, including medically necessary home health or private duty nursing, as applicable, shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and EPSDT benefits.

2.8.11 Evaluation

2.8.11.1 The CONTRACTOR shall collect and report process and outcome data as indicated on Population Health quarterly and annual report templates provided by TENNCARE. Outcome data for these reports will include short, intermediate and long term measures.

2.8.11.2 The CONTRACTOR shall provide in the annual report for the programs, with interactive interventions, an active participation rate as designed by NCQA.

2.8.11.3 The CONTRACTOR shall evaluate and report member satisfaction based upon NCQA requirements, on Population Health programs with interactive interventions.

2.8.11.4 The CONTRACTOR shall assess member's functional status, using the SF12 survey, or other appropriate tool used for children or the intellectually disabled, for members in the high risk Chronic Care Management program and the Complex Case Management program.

2.8.12 Special Projects

2.8.12.1 New Member mini Heath Risk Assessments. The CONTRACTOR shall make reasonable attempts to assess member's health risks. Information such as weight, nutrition, substance abuse and physical inactivity collected from assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

2.8.12.1.1 During 2013, the first year of implementation, the CONTRACTOR shall continue to conduct their current new member HRA and identify the method for incorporating HRA information into the identification system for eligibility into Population Health programs.

2.8.12.1.2 As appropriate, the CONTRACTOR's Population Health staff shall participate in a collaborative MCO/TennCare workgroup to identify a common standard new enrollee HRA and address innovative ways to improve member completion rates.

2.8.12.2 The CONTRACTOR shall conduct at least one rapid cycle improvement project annually. The rapid cycle improvement projects shall address increasing member engagement rates in the High Risk opt in level of Population Health programs. The project plan is to be reported in the quarterly report before implementation. The project should then be conducted with the results to be reported in the next Population Health Quarterly Report.

2.8.13 Milestones for the Sixth Month (January 1 to July 1, 2013) Transition Period from Disease Management to Population Health

2.8.13.1 The CONTRACTOR shall by January 1, 2013 stratify all members into the three risk categories described in Section 2.8.1.1.

2.8.13.2 The CONTRACTOR shall by March 31, 2013 have all disease management managed members receiving services at the end of the fourth quarter of 2012 transitioned to the new level 1 or level 2 Population Health programs.

2.8.13.3 The CONTRACTOR shall by January 31, 2013 have all members engaged in case management, at the end of the fourth quarter of 2012, transitioned to the appropriate Level 2 Population Health program.

2.8.13.4 The CONTRACTOR shall by April 30, 2013 have submitted all required operational data for the first three months of the transition period.

2.8.13.5 The CONTRACTOR shall by April 30, 2013 provide evidence in the quarterly Population Heath Quarterly report, as cited above, that a method is in place to identify the targeted population for prenatal visit verification. (see Section 2.8.4.2.3)

2.8.13.6 The CONTRACTOR shall by July 1, 2013 have operationalized Population Health to provide all minimum interventions to enrollees who are not participating in a medical home lock in project, in the appropriate programs.

12. Section 2.9.5.3 shall be deleted in its entirety and the remaining Section 2.9.5 shall be renumbered accordingly, including any references thereto.

13. Section 2.9.6.1.4 shall be amended by adding new language to the end of the existing language as follows:

2.9.6.1.4 Long-term care services identified through care coordination and provided by the CONTRACTOR shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services

that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance. However, once a member qualifies for CHOICES, he is no longer eligible to receive services under the State-funded Options program (see Rule 0030-2-1-.01), and neither the State nor the CONTRACTOR can require that services available to a member through CHOICES be provided instead through programs funded by Title III of the Older Americans Act.

14. Section 2.9.6.1.6 shall be deleted and replaced as follows:

2.9.6.1.6 The CONTRACTOR shall compute Care Coordination CHOICES-related timelines as follows;

2.9.6.1.6.1 The date of receipt of the referral by the CONTRACTOR (which shall not include any additional days for the CONTRACTOR to process the referral or assign to appropriate staff) shall be the anchor date for the referral process. The anchor date is not included in the calculation of days.

2.9.6.1.6.2 The anchor date for the enrollment process shall be the latter of 1) the date the Bureau transmits the 834 file to the CONTRACTOR; or 2) the date of CHOICES enrollment as indicated on the 834 file. The anchor date is not included in the calculation of days.

2.9.6.1.6.3 The Business Day (see Section 1) immediately following the anchor date is day one (1) of timelines utilizing business days. Each subsequent business day is included in the computation.

2.9.6.1.6.4 The calendar day immediately following the anchor date is day one (1) of timelines utilizing calendar days. Each subsequent calendar day is included in the computation.

15. Section 2.9.6.1.9 shall be deleted and replaced as follows:

2.9.6.1.9 The CONTRACTOR shall ensure that, upon enrollment into CHOICES, the appropriate level of Population Health (see Section 2.8.4 of this Agreement) activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's Population Health programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the care coordinator/care coordination team.

16. Section 2.9.6.2.3 shall be deleted and replaced as follows and all references shall be updated accordingly.

2.9.6.2.3 *Functions of the Single Point of Entry (SPOE)*

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TENNCARE and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES, and (2) whether the applicant appears to meet level of care eligibility for enrollment in CHOICES.

2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; and assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.

2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) complete Medicaid and level of care (i.e., PAE) applications and provide assistance, as necessary, in gathering documentation needed by the State to determine TENNCARE eligibility; (4) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (5) for applicants seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (6) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TENNCARE; (7) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (8) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment in accordance with protocols developed by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's

decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (9) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.2.3.6 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES, the member's CHOICES Group, and any applicable patient liability amounts (See Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.

2.9.6.2.3.7 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and documentation of the discussion regarding identified risk and mitigation strategies.

17. Section 2.9.6.2.5 shall be amended by adding new Sections 2.9.6.2.5.8 through 2.9.6.2.5.9.2 as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the Care Coordinator shall make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting;

2.9.6.2.5.8.1 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the member's individual cost neutrality cap, the Care Coordinator shall assist the member in transitioning to a more appropriate care delivery setting, or if the member refuses, proceed with disenrollment from CHOICES.

2.9.6.2.5.9 As part of the face-to-face visit for members in CHOICES Group 3, the Care Coordinator shall provide explanation to the member regarding the fifteen thousand dollar ($15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of

$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers;

2.9.6.2.5.9.1 If the member has been conditionally enrolled into CHOICES Group 3 and is in a nursing facility, the Care Coordinator shall work with the nursing facility to coordinate timely transition to the community and initiation of CHOICES HCBS.

2.9.6.2.5.9.2 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the array of services and supports that would be available as described in 2.9.6.5.9, the Care Coordinator shall, pursuant to protocols established by TENNCARE, coordinate with TENNCARE to review the member's level of care, and if nursing facility level of care is approved, to facilitate transition to CHOICES Group 1 or 2.

18. The renumbered Sections 2.9.6.2.5.10 and 11 shall be deleted and replaced as follows:

2.9.6.2.5.10 As part of the face-to-face visit for members in CHOICES Group 2 or Group 3, the care coordinator shall review, and revise as necessary, the member's risk assessment, develop a risk agreement ,and have the member or his/her representative sign and date the risk agreement.

2.9.6.2.5.11 As part of the face-to-face visit, for members determined to need eligible CHOICES HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also, using current information regarding the CONTRACTOR's network, provide member education regarding choice of contract providers for CHOICES HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.

19. Section 2.9.6.3.1.3 shall be amended by deleting the phrase "DM MCO case management," and replacing it with "Population Health" as follows:

2.9.6.3.1.3 Referral from CONTRACTOR's staff including but not limited to Population Health and UM staff;

20. Section 2.9.6.3.1.5.4 shall be amended by deleting and replacing the word "DM" with the words "Population Health" as follows:

2.9.6.3.1.5.4 Data collected through the Population Health and/or UM processes.

21. Section 2.9.6.3.2 shall be amended by deleting and replacing the acronym "MOE" with the words "CHOICES At-Risk".

22. Section 2.9.6.3.9 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in gathering documentation needed by DHS to determine categorical/financial eligibility for LTC; (4) for members seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (5) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for members who want to receive nursing facility services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (8) for members seeking enrollment in Group 2, make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; (9) for members seeking enrollment in Group 3, provide explanation to the member regarding the fifteen thousand dollar ($15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and (10) for all members, using current information regarding the CONTRACTOR's network, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

23. Section 2.9.6.5.1.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

24. Section 2.9.6.6.1.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

25. Section 2.9.6.8.2 shall be amended by deleting and replacing the words "MCO Case Management" with "Population Health" and updating the reference to Section "2.9.5.4.1" with "2.9.5.3.1".

26. The first sentence of Section 2.9.6.8.7 shall be amended by deleting the phrase "using a tool and protocol specified" and replacing it with the phrase "in accordance with protocols developed".

27. Section 2.9.6.9.1.1.2 shall be amended by deleting and replacing the words "disease management" with "Population Health".

28. Section 2.9.6.9.3.1.1shall be amended by deleting and replacing Section 2.9.6.9.3.1.1.1 and adding new Sections 2.9.6.9.3.1.1.3 through 2.9.6.9.3.1.1.3.2 as follows:

2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care, or if the assessment was prompted by a request by a member, a member's representative or caregiver or another entity for a change in level of services, the level of care shall be forwarded to TENNCARE for determination;

2.9.6.9.3.1.1.3 For all persons enrolled into the CHOICES program (CHOICES Group 1 or 2) prior to implementation of the new NF Level of Care (LOC) criteria on July 1, 2012, the CONTRACTOR shall be obligated to assess the person's LOC as follows:

2.9.6.9.3.1.1.3.1 The CONTRACTOR shall, for purposes of LOC eligibility to remain in the CHOICES Group in which the member is enrolled, assess the member's LOC eligibility be based on the criteria in place at the time of the member's enrollment into that CHOICES group.

2.9.6.9.3.1.1.3.2 The CONTRACTOR shall also, for purposes of complying with the Terms and Conditions of the State's Waiver, assess the member's LOC eligibility based on the new LOC criteria in place as of July 1, 2012. The CONTRACTOR shall report the results of the LOC reassessment to TENNCARE. This information will be used by the State in its expenditure reporting to CMS.

29. Section 2.9.6.9.3.3 shall be amended by deleting and replacing the words "disease management" with "Population Health".

30. The third sentence in Section 2.9.6.10.9 shall be amended by deleting the phrase "as applicable," between the words "agreement" and "shall" as follows:

2.9.6.10.9 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as

well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, shall be signed by the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

31. Section 2.9.6.11.18.21 shall be amended by deleting and replacing the words "disease management" with "Population Health".

32. Section 2.9.6.11.18 shall be amended by adding new Sections 2.9.6.11.18.32 through 2.9.6.11.18.35 as follows:

2.9.6.11.18.32 The Care Coordinator's role and responsibility in implementing the Advance Determination process including qualifying criteria, when the process may be implemented, and what documentation must be presented to support the determination pursuant to TENNCARE rule 12 13 01-05.

2.9.6.11.18.33 The Care Coordinator's role and responsibility in assessing members who have been conditionally enrolled into CHOICES and coordination with the nursing facility to facilitate timely transition, when appropriate.

2.9.6.11.18.34 The Care Coordinator's role and responsibility in facilitating denial of enrollment into or termination of enrollment from CHOICES Groups 2 or 3 when a determination has been made that the applicant or member (as applicable) cannot be safely served within the member's cost neutrality cap (CHOICES Group 2) or Expenditure Cap (CHOICES Group 3).

2.9.6.11.18.35 The Care Coordinator's role and responsibility in facilitating access to other medically TennCare covered benefits, including home health and behavioral health services.

33. The fifth paragraph in Section 2.9.7.4.10.10 shall be amended by deleting the phrase "as applicable," between the words "agreement" and "shall" as follows:

2.9.7.4.10.10 The CONTRACTOR shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. Once a referral has been made to the FEA for consumer direction, the member's supports broker should be involved in risk assessment and risk planning activities whenever possible. The new or updated risk agreement shall be signed by the member or his/her representative (as applicable). The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file

34. Section 2.9.8.3.6 shall be amended by deleting and replacing the word "Tennessee" with the word "TENNCARE".

35. Section 2.9.8.8.1 shall be amended by adding a new Section 2.9.8.8.1.1 as follows:

2.9.8.8.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year. However, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

36. Section2.9.9.1 shall be deleted and replaced as follows:

2.9.9.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health, behavioral health, and long-term care services. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term care services and ensuring collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical health and behavioral health providers, screening for long-term care needs, exchange of information, confidentiality, assessment, treatment plan and plan of care development and implementation, collaboration, , care coordination (for CHOICES members) and Population Health, provider training, and monitoring implementation and outcomes.

37. Section 2.9.9.8 shall be deleted and replaced as follows:

2.9.9.8 Population Health and CHOICES Care Coordination

The CONTRACTOR shall use its Population Health, and CHOICES care coordination programs (see Sections 2.9.5, 2.8, and 2.9.6) to support the continuity and coordination of covered physical health, behavioral health, and long-term care services and the collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on Population Health stratification (see Section 2.8.3), to be enrolled in an appropriate level Population Health Program (see Section 2.8.4 of this Agreement). For CHOICES members, Population Health activities shall be integrated with the care coordination process (see Sections 2.9.5.3, and 2.9.6.1.9).

38. Section 2.9.11.3.1 shall be deleted and replaced as follows:

2.9.11.3.1 Analyzing prescription drug data and/or reports provided by the PBM or TENNCARE to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to Population Health programs and/or refer them to CHOICES intake (see Section 2.9.6) as appropriate; if a CHOICES member is identified as a high-utilizer or as inappropriately using pharmacy services, relevant prescription drug data and/or reports for the member shall be provided to the member's care coordinator, and the care coordinator shall take appropriate next steps, which may include coordination with the member's PCP

39. Section 2.9 shall be amended by adding a new 2.9.14 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.14 Coordination with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) regarding the CONTRACTOR's Full Benefit Dual Eligible (FBDE) Members Enrolled in a D-SNP

2.9.14.1 The CONTRACTOR shall modify its IT systems to accept Medicare enrollment data and to load the data in the CONTRACTOR's case management system for use by Care Coordinators and case management, DM/Population Health and UM staff.

2.9.14.2 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting.

2.9.14.2.1 The CONTRACTOR shall develop, for review and approval by TENNCARE, policies, procedures and training for CONTRACTOR staff, including Care Coordinators, regarding coordination with a FBDE member's D-SNP in discharge planning from an inpatient setting to the most appropriate, cost effective and integrated setting.

2.9.14.2.2 The CONTRACTOR shall receive and process in a timely manner a standardized electronic Daily Inpatient Admissions, Census and Discharge Report, from each D-SNP operating in the Grand Region served by the CONTRACTOR.

2.9.14.2.3 The CONTRACTOR shall provide a technical contact to address any technical problems in the submission of the daily Report.

2.9.14.2.4 The CONTRACTOR shall establish processes to ensure that notifications of inpatient admission are timely and appropriately triaged.

2.9.14.2.5 The CONTRACTOR shall establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CHOICES members, that Care Coordinators are notified/engaged as appropriate.

2.9.14.2.6 The CONTRACTOR shall maintain daily reports for audit to determine appropriate and timely engagement in discharge planning.

2.9.14.3 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding CHOICES LTSS that may be needed by the member; however, the D-SNP shall remain responsible for ensuring access to all Medicare benefits covered by the CONTRACTOR, including SNF and home health, and shall not supplant such medically necessary covered services with services available only through TennCare.

2.9.14.3.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures and training for processing in a timely manner requests for CHOICES LTSS from a FBDE member's D-SNP, including communication with the member's Care Coordinator and/or UM staff, response to the D-SNP submitter, collaboration between the Medical Director(s) of the D-SNP and MCO regarding medical necessity denials, and escalation procedures/contacts.

2.9.14.4 The CONTRACTOR shall coordinate with a FBDE member's D-SNP to ensure timely access to medically necessary covered Medicare benefits needed by a FBDE member, including members enrolled in the CHOICES program.

2.9.14.4.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures and training for staff, including Care Coordinators, regarding service requests to a FBDE member's D-SNP for Medicare benefits needed by the member.

2.9.14.5 The CONTRACTOR shall request, when appropriate, the D-SNP's participation in needs assessments and/or the development of an integrated person-centered plan of care for a TennCare CHOICES member, encompassing Medicare benefits provided by the CONTRACTOR as well as Medicaid benefits provided by the TennCare MCO.

2.9.14.5.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures, and training for engaging D-SNP participation in the CHOICES needs assessment/care planning process for a FBDE member, including the roles/responsibilities of the TennCare MCO and the D-SNP.

2.9.14.6 The CONTRACTOR shall submit to a FBDE member's D-SNP, as applicable and appropriate, referrals for case management and/or disease management/Population Health.

2.9.14.6.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies procedures and training for staff regarding the D-SNP case management and/or disease management/Population Health referral process.

2.9.14.7 The CONTRACTOR shall coordinate with each D-SNP operating in the Grand Region served by the CONTRACTOR and with the D-SNP's providers (including hospitals and physicians) in the CONTRACTOR's implementation of its nursing facility diversion program.

2.9.14.7.1 The CONTRACTOR shall provide to D-SNPs training on the CONTRACTOR's NF Diversion program, including the referral process.

2.9.14.7.2 The CONTRACTOR shall, pursuant to Section 2.9.6, accept and process from a member's D-SNP a referral for HCBS in order to delay or prevent NF placement.

2.9.14.8 The CONTRACTOR shall, pursuant to Section 2.9.6 receive and process from a FBDE member's D-SNP a referral for transition from a SNF to the community, and shall coordinate with the FBDE member's D-SNP to facilitate timely transition, as appropriate, including coordination of services covered by the CONTRACTOR and services covered by the D-SNP.

2.9.14.8.1 The CONTRACTOR shall provide to D-SNPs training on the CONTRACTOR's NF-to-community transition program, including the referral, screening and assessment process.

2.9.14.9 The CONTRACTOR shall participate, as appropriate, in D-SNP training regarding D-SNP responsibilities for coordination of Medicare and Medicaid benefits for FBDE members and benefits covered under the TennCare program, including CHOICES.

40. Section 2.11.1.3 shall be amended by adding a new Section 2.11.1.3.7 as follows:

2.11.1.3.7 Not discriminate against providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective "federal health care provider conscience protection statutes," referenced individually as 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, 2010, Public Law 111–117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279–80.

41. Section 2.11.6.1 shall be deleted and replaced in its entirety.

2.11.6.1 The CONTRACTOR shall contract with all current nursing facilities (as defined in TCA 71-5-1412(b)), that meet all CMS certification requirements, for a minimum of three (3) years following the effective date of CHOICES implementation. Pursuant to Public Chapter 971, such period is extended through June 30, 2015 if the facility is willing to contract with the CONTRACTOR under the same terms and conditions offered to any other participating facility; however this does not prevent the CONTRACTOR from enforcing the provisions of its contract with the facility. Thereafter, the CONTRACTOR shall contract with a sufficient number of nursing facilities in order to have adequate capacity to meet the needs of CHOICES members for nursing facility services

42. Section 2.11.6 shall be amended by deleting and replacing Section 2.11.6.7 and by adding a new Section 2.11.6.8 as follows:

2.11.6.7 The CONTRACTOR shall assist in developing an adequate qualified workforce for covered long-term care services. The CONTRACTOR shall actively participate with TENNCARE, other TennCare managed care contractors, and other stakeholders as part of a statewide initiative to develop and implement strategies to increase the pool of available qualified direct care staff and to improve retention of qualified direct care staff. The strategies may include, for example, establishing partnerships with local colleges and technical training schools to develop and implement training and/or certification programs for direct support staff; creating a registry of trained and/or certified staff with the ability to match people who need assistance with staff to provide such assistance based on individualized needs and preferences; providing incentives for providers who employ specially trained and/or certified staff and who assign staff based on member needs and preferences; and systems to encourage direct support staff to engage as an active participant in the care coordination team. The CONTRACTOR's active participation in this statewide initiative shall fulfill its obligation under this section; however the CONTRACTOR is not prohibited for pursuing additional

workforce development activities. The CONTRACTOR shall report annually to TENNCARE on the status of any additional qualified workforce development strategies it elects to implement (see Section 2.30.8.7)

2.11.6.8 TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

2.11.6.8.1 The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

43. Section 2.12.9.4 shall be deleted and replaced as follows:

2.12.9.4 Failure by the provider to obtain written approval from the CONTRACTOR for a subcontract that is for the purposes of providing TennCare covered services may lead to the contract being declared null and void at the option of TENNCARE. Claims submitted by the subcontractor or by the provider for services furnished by the subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under Federal and State false claims statutes or be subject to be recouped by the CONTRACTOR and/or TENNCARE as overpayment;

44. Section 2.12.9.61 shall be amended by adding the words "public" and "in English and Spanish" as follows:

2.12.9.61 Require that the provider display public notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices in English and Spanish;

45. Section 2.12.9.65 shall be deleted and replaced as follows:

2.12.9.65 Specify that the provider agreements include the following nondiscrimination provisions:

2.12.9.65.1 Language that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin shall be excluded from participation in, except as specified in Section 2.3.5, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the CONTRACTOR or in the employment practices of the provider.

2.12.9.65.2 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.12.9.65.3 Require the provider to agree to cooperate with TENNCARE and the CONTRACTOR during discrimination complaint investigations.

2.12.9.65.4 Require the provider to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the CONTRACTOR's Nondiscrimination Office.

46. Section 2.13.8 shall be deleted and replaced in its entirety and shall read as follows:

2.13.8 **Medicaid Payment for Primary Care**

2.13.8.1 In accordance with the Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act), for calendar years 2013 and 2014, the CONTRACTOR shall make payments for certain primary care services (as described by CMS) and furnished by primary care providers (as described by CMS and TENNCARE) in an amount that has been determined by CMS.

2.13.8.2 In addition to the routine claims payment reports required by this Agreement, the CONTRACTOR shall report to TENNCARE any information related to this requirement in a format described by TENNCARE.

47. Sections 2.14.1.16.2 and 2.14.1.16.5 shall be deleted and replaced as follows:

2.14.1.16.2 Enroll non-CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) and may use the information to identify members who may be eligible for CHOICES in accordance with the requirements in Section 2.9.6.3 if appropriate;

2.14.1.16.5 Assess the most likely cause of high utilization and develop a Population Health Complex Case Management (see Section 2.8.4 of this Agreement) plan based on results of the assessment for each non-CHOICES member.

48. Section 2.14.2.3 shall be deleted and replaced as follows:

2.14.2.3 Prior authorization requests shall be processed in accordance with 42 CFR § 438.210(d) and the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. Instances in which an enrollee's health condition shall be deemed to require an expedited authorization decision by the CONTRACTOR shall include requests for home health services for enrollees being discharged from a hospital or other inpatient setting when such home health services are needed to begin upon discharge.

49. Section 2.14.3.5.2 shall be amended by adding the words "hard copy" as follows:

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the hard copy provider directory in Section 2.17.8.

50. Section 2.14.5 shall be amended by adding a new Section 2.14.5.5 as follows and the remaining Section shall be renumbered accordingly including any references thereto.

2.14.5.5 The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

51. Section 2.14.9.3 shall be deleted and replaced as follows:

2.14.9.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.14.1.16 of this Agreement, members who establish a pattern of accessing emergency room services shall be referred to the appropriate Population Health Program for follow-up services.

52. Section 2.15.1.6 shall be amended by adding a new Section 2.15.1.6.2 as follows and renumbering the remaining Sections accordingly including any references thereto.

2.15.1.6.2 The CONTRACTOR shall participate in workgroups and agree to establish and implement policies and procedures, including billing and reimbursement, that are agreed to and/or described by TENNCARE in order to address specific quality concerns. These initiatives shall include but not be limited to identification of prenatal and postpartum visits in a time effective manner especially when a provider bills for total obstetrical care using a global billing code.

53. Section 2.15.3.1.1 shall be deleted and replaced as follows:

2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one (1) in the area of either child health or perinatal (prenatal/postpartum) health.

54. Section 2.15.4 shall be deleted and replaced as follows:

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its Population Health Programs (see Section 2.8.6 of this Agreement). The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years. The CONTRACTOR is required to maintain an archive of its clinical practice guidelines for a period of five (5) years. Such archive shall contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for Program Integrity purposes.

55. Section 2.15.6.1.1 shall be amended by adding a new sentence at the end of the existing text as follows:

2.15.6.1.1 Beginning with HEDIS 2012, the CONTRACTOR shall utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. If, in the event the CONTRACTOR fails to pass the medical record review for any given standard and NCQA *mandates* administrative data must be submitted instead of hybrid, the administrative data may be used.

56. Section 2.15.7.1.3 shall be amended by deleting and replacing Section 2.15.7.1.3.3, adding a new Section 2.15.7.1.3.4 and renumbering the existing Section accordingly including any references thereto.

2.15.7.1.3.3 Theft against a CHOICES member;

2.15.7.1.3.4 Financial exploitation of a CHOICES member;

57. Section 2.17.5.2 through 2.17.5.2.1.1.3 shall be deleted and replaced as follows:

2.17.5.2 Teen Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

2.17.5.2.1 The Teen Newsletter shall be a product of the TENNderCare MCC Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

2.17.5.2.1.1.2 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

58. Section 2.17.8 shall be deleted and replaced as follows:

2.17.8 **Provider Directories**

2.17.8.1 The CONTRACTOR shall distribute information regarding general provider directories (see Section 2.17.8.5 below) to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date. Such information shall include how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers.

2.17.8.2 The CONTRACTOR shall provide information regarding the CHOICES provider directory (see Section 2.17.8.6 below) to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than thirty (30) days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers.

2.17.8.3 The CONTRACTOR shall also be responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES provider directory. A PDF copy of the hard copy version shall not meet this requirement. The online searchable version of the general provider directory and the CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the CONTRACTOR shall make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members. The hard copy of the general provider directory and the CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the CONTRACTOR's website of the general provider directory or the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers, including the searchable electronic version of the general provider directory and the CHOICES provider directory and the CONTRACTOR's member services line.

2.17.8.4 Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.

2.17.8.5 The CONTRACTOR shall develop and maintain a general provider directory, which shall be made available to all members. The provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory shall include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; and identification of whether or not a provider performs TENNderCare screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.

2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES provider directory that includes long-term care providers. The CHOICES provider directory, which shall be made available to all CHOICES members, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) CHOICES HCBS providers with the name, location, telephone number, and type of services by county of each provider. The CHOICES provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the CHOICES provider directory shall be updated on a daily basis.

59. Section 2.18.2 shall be deleted and replaced as follows:

2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language interpreter and translation services, including effective communication assistance in alternative formats, such as, auxiliary aids to any member who needs such services The CONTRACTOR shall provide language and cultural competence training to subcontractors and contracted providers which shall include the potential impact of linguistic and cultural barriers on utilization, quality and satisfaction with care and how and when to access interpreter services and to promote their appropriate use during the medical encounter.

2.18.2.2 The CONTRACTOR shall provide language interpreter and translation services including effective communication assistance in alternative formats, such as, auxiliary aids free of charge to members.

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

60. Section 2.18.6 shall be amended by adding a new Section 2.18.6.13 and renumbering the remaining Section accordingly, including any references thereto. The renumbered Section 2.18.6.14 shall be deleted and replaced as follows:

2.18.6.13 The CONTRACTOR shall submit all general correspondence intended for mass distribution that affects provider reimbursement, claims processing procedures, or documents that are referenced as a part of a CONTRACTOR's provider agreement template(s) (see Section 2.12.2) to TDCI for review and approval or acceptance, as appropriate (e.g., provider handbooks, newsletters, alerts, notices, reminders, other education material, etc.).

2.18.6.14 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. For providers located in Tennessee and out-of-state providers located in contigious counties, at least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that provide evidence of compliance with the requirement in this Section 2.18.6.14, including when and how contact is made for each contract provider. The CONTRACTOR may submit an alternative plan to accomplish the intent of this requirement for review and approval by TENNCARE.

61. Section 2.20.2.4 shall be amended by adding the word "tips," in front of the word "confirmed" and by adding a new Section 2.20.2.4.1 and renumbering the remaining Section accordingly, including any references thereto.

2.20.2.4 The CONTRACTOR shall report all tips, confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.4.1 All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to TennCare Office of Program Integrity and TBI MFCU;

62. Section 2.22.4 shall be amended by adding new Sections 2.22.4.11 through 2.22.4.12 as follows:

2.22.4.11 For purposes of timely filing (see Section 2.12.9.28):

2.22.4.11.1 For institutional claims that include span dates of service (i.e., a 'From' and 'Through' date on the claim), the 'Through' date on the claim shall be used for determining the date of service for claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service or "Through" date on a span bill, whichever is later, for submission of a valid, complete claim.

2.22.4.11.2 For claims submitted by physicians and other suppliers that include span dates of service, the line item 'From' date shall be used for determining the date of service for claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service or "Through" date on a span bill, whichever is later, for submission of a valid, complete claim.

2.22.4.11.3 For claims submitted by physicians and other suppliers that do not include span dates of service, the date of service shall be used for determining claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service, whichever is later, for submission of a valid, complete claim.

2.22.4.11.4 Beginning with claims for dates of service January 1, 2013 and following, except for 1) recovery of overpayments as required pursuant to Section 6402 of the Affordable Care Act and TENNCARE policy; and 2) retrospective adjustments of a nursing facility's per diem rate(s) (see Section 2.13.3.4), paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 120 days of the date of payment notification. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

2.22.4.11.5 The provider has the right to file a dispute if he or she disagrees with a claim decision regarding the denial or compensation of a claim in accordance with section (2.12.9.)

2.22.4.11.6 The CONTRACTOR shall specify in its provider manual a period of time that is consistent with these requirements and to the extent that this reflects a change in the CONTRACTOR's current provider manual, shall issue notification to providers on or before January 2, 2013.

2.22.4.12 The CONTRACTOR shall, for a period to be determined by TENNCARE, permit CHOICES Nursing Facility and HCBS providers to resubmit and shall process any institutional or HCBS claims for dates of service on or after March 1, 2010, that were denied on the basis of timely filing when the claim was filed in accordance with 2.22.4.11.1, 2.22.4.11.2, or 2.22.4.11.3, as applicable, or for which the applicable minimum reprocessing time was not provided.

63. Section 2.23.4.3.7 shall be amended by adding the phrase (see Section 2.30.18.3) in the last sentence.

64. Section 2.23.5.2 shall be deleted and replaced as follows:

2.23.5.2 The CONTRACTOR shall systematically update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.

65. Section 2.25.9.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

66. Section 2.26.9 shall be amended by adding the words "and providers" as follows:

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

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

67. Section 2.28.6 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

68. The renumbered Sections 2.28.6 and 2.28.7 shall be deleted and replaced as follows:

2.28.6 All discrimination complaints against the CONTRACTOR, CONTRACTOR's employees, CONTRACTOR's providers, CONTRACTOR's provider's employees and CONTRACTOR's subcontractors shall be resolved according to the provisions of this Section 2.28.6.

2.28.6.1 Discrimination Complaints against the CONTRACTOR and/or CONTRACTOR's Employees. When complaints concerning alleged acts of discrimination committed by the CONTRACTOR and/or its employees related to the provision of and/or access to TennCare covered services are reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall send such complaints within two (2) business days of receipt to TENNCARE. TENNCARE shall investigate and resolve all alleged acts of discrimination committed by the CONTRACTOR and/or its employees. The CONTRACTOR shall assist TENNCARE during the investigation and resolution of such complaints. TENNCARE reserves the right to request that the CONTRACTOR's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If a request for assistance with an initial investigation is made by TENNCARE, the CONTRACTOR's nondiscrimination compliance officer shall provide TENNCARE with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.

2.28.6.2 Discrimination Complaints against the CONTRACTOR's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, provider's employees and/or subcontractors related to the provision of and/or access to TennCare covered services be reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall inform TENNCARE of such complaints within two (2) business days from the date CONTRACTOR learns of such complaints. The CONTRACTOR's nondiscrimination compliance officer shall, within five (5) business days of receipt of such complaints, begin to document and conduct the initial investigations of the complaints. Once an initial investigation has been completed, the CONTRACTOR's nondiscrimination compliance officer shall report his/her determinations to TENNCARE. At a minimum, the CONTRACTOR's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. TENNCARE reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, and subcontractors.

2.28.6.3 Corrective Action Plans to Resolve Discrimination Complaints. If a discrimination complaint against the CONTRACTOR, CONTRACTOR's employees, CONTRACTOR's providers, CONTRACTOR's provider's employees, or CONTRACTOR's subcontractors is determined by TENNCARE to be valid, TENNCARE shall, at its option and pursuant to Section 2.25.10, either (i) provide the CONTRACTOR with a corrective action plan to resolve the complaint, or (ii) request that the CONTRACTOR submit a proposed corrective action plan to TENNCARE for review and approval that specifies what actions the CONTRACTOR proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to CONTRACTOR by TENNCARE, or approval of the CONTRACTOR's proposed corrective action plan by TENNCARE, the CONTRACTOR shall implement the approved corrective action plan to resolve the discrimination complaint. TENNCARE, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify CONTRACTOR of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by TENNCARE. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by TENNCARE.

2.28.7 The CONTRACTOR shall use and have available to TennCare enrollees, TennCare's Discrimination complaint form located on TennCare's website under the nondiscrimination link at http://www.tn.gov/tenncare/members.shtml. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be available in English and Spanish. When requests for assistance to file a discrimination complaint are made by enrollees, the CONTRACTOR shall assist the enrollees with submitting complaints to TENNCARE. In addition, the CONTRACTOR shall inform its employees, providers, and subcontractors how to assist TENNCARE enrollees with obtaining discrimination complaint forms and assistance from the CONTRACTOR with submitting the forms to TENNCARE and the CONTRACTOR.

69. Section 2.29.1.3.19 shall be deleted and replaced as follows:

2.29.1.3.19 A staff person responsible for all Population Health and related issues, including but not limited to, Population Health activities and coordination between physical and behavioral health services;

70. Section 2.29.1.4 shall be deleted and replaced as follows:

2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, Population Health, care coordination, QM/QI, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.

71. Section 2.29.1.9 shall be deleted and replaced as follows:

2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, UM staff,

appeals staff, , Population Health Complex Case Management staff care coordination staff, consumer advocate, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.

72. Section 2.30.5 and 2.30.5.1shall be deleted and replaced as follows:

2.30.5 Disease Management/Population Health Reports

2.30.5.1 The CONTRACTOR shall submit a quarterly *Population Health Update Report* addressing all seven (7) Population Health Programs (see Section 2.8.4 of this Agreement). The report shall include process and operational data and any pertinent narrative to include any staffing changes, training or new initiatives occurring in the reporting period.

73. Section 2.30.5.3 shall be deleted and replaced as follows:

2.30.5.3 The CONTRACTOR shall submit on March 30, 2013, a *Population Health Program Description* following the guidance provided by TENNCARE addressing Section 2.8 of this Agreement. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk Level. The program description shall also include a CHOICES narrative as outlined in Section 2.8.11 of this Agreement and address the Clinical Practice Guidelines reference in Section 2.8.6 of this Agreement.

74. Section 2.30.6.1 through 2.30.6.1.3 shall be deleted and replaced as follows:

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.5 of the prior Agreement by July 1 of 2013.

75. Section 2.30.8.1 shall be deleted and replaced as follows:

2.30.8.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical, behavioral health, and long-term care providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, CHOICES HCBS providers, and emergency and non-emergency transportation providers. For CHOICES HCBS providers, the *Provider Enrollment File* shall identify the type(s) of CHOICES HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver CHOICES HCBS, by service type. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. During any period of readiness review, the CONTRACTOR shall submit this

report as requested by TENNCARE. Each monthly *Provider Enrollment File* shall include information on all providers of covered services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

76. Section 2.30.8.7 shall be deleted and replaced as follows:

2.30.8.7 The CONTRACTOR shall submit an annual *CHOICES Qualified Workforce Strategies Report* that describes any additional strategies the CONTRACTOR elects to undertake to assist in the development of an adequate qualified workforce for covered long-term care services, increase the available qualified direct care staff, and improve the retention of qualified direct care staff (see Section 2.11.6.7). At a minimum, the report shall include a brief description of each of any additional strategies the CONTRACTOR elects to undertake; activities associated with each of the CONTRACTOR's strategies, including associated partnerships; timeframes for implementing each strategy and associated activities; the status of each strategy and associated activities; and a brief summary of the current and anticipated impact of each strategy and associated activities. Should the CONTRACTOR elect not to pursue additional activities (beyond the statewide initiative), this report shall be submitted timely and shall report that the CONTRACTOR has elected not to pursue additional activities beyond the statewide initiative.

77. Section 2.30.12.6 shall be deleted and replaced by new Sections 2.30.12.6 and 7 and the remaining Sections of 2.30.12 shall be renumbered accordingly, including any references thereto.

2.30.12.6 The CONTRACTOR shall submit an annual *Report of Audited HEDIS Results* by June 15 of each year (see Sections 2.15.6).

2.30.12.7 The CONTRACTOR shall submit an annual Report of Audited CAHPS Results by June 15 of each year (see Sections 2.15.6).

78. The existing Section 2.30.12.9 shall be deleted in its entirety including any references thereto.

79. Section 2.30.13.3 shall be deleted in its entirety and the renumbered Section 2.30.13.3 shall be deleted and replaced by new Sections 2.30.13.3 and 4 as follows:

2.30.13.3 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that encompasses behavioral and physical health. The report shall summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement (see Section 2.18.7.4) The report shall be submitted by July 1 each year.

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

80. Section 2.30.16.2.1 shall be amended by deleting the reference to Section "2.30.17.3" and replacing it with the reference to "2.30.18.3".

81. Section 2.30.18 shall be amended by adding a new Section 2.30.18.4 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.30.18.4 The CONTRACTOR shall submit a quarterly *Encounter/MLR Reconciliation Report* and a *Companion Data File* to demonstrate the reconciliations between the submissions of encounter files and MLR Claim Triangle reports.

2.30.18.4.1 The companion data file shall be in an Excel format and shall represent a claim triangle report in terms of claim counts and total payment based on all encounter batch files submitted to TennCare EDI during the prior quarter with delineations by 'paid month', 'incurred month', 'claim types (as it is defined in the MLR Triangle report)', and 'encounter batch file ID'.

2.30.18.4.2 The reconciliation report shall include an overall assessment of reporting integrities between the two Claim Triangle reports in terms of counts and amount based on the common delineations. When the two reports are not reconciling under the common delineations, the CONTRACTOR shall address the root causes of the gaps with proposed corrective action plans.

82. Section 2.30.22.2 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

83. The renumbered Section 2.30.22.2 shall be deleted and replaced as follows:

2.30.22.2 Annually, TENNCARE shall provide the CONTRACTOR with a Nondiscrimination Compliance Plan Template. The CONTRACTOR shall answer the questions contained in the Compliance Plan Template and submit the completed *Compliance Plan* to TENNCARE within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, but is not limited to, the Assurance of Nondiscrimination. The signature date of the CONTRACTOR's Nondiscrimination Compliance Plan shall be the same as the signature date of the CONTRACTOR's Assurance of Nondiscrimination. These deliverables shall be in a format specified by TENNCARE.

84. The renumbered Section 2.30.22.3.2 shall be deleted and replaced as follows:

2.30.22.3.2 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: identity of the complaintant, complainant's relationship to the CONTRACTOR, circumstances of the complaint, type of covered service related to 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. For each complaint reported as resolved the CONTRACTOR shall submit a copy of the complainant's letter of resolution.

85. Section 3.1.2 shall be amended by deleting the phrase ",any payments related to FQHC/RHC costs" and by deleting the reference to "(see Section 3.15)" so that the amended Section 3.1.2 shall read as follows:

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, any payments for claims incurred during a period of retroactive eligibility greater than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR, any incentive payments (if applicable) and any payments that offset the CONTRACTOR's cost for the development and implementation of an electronic visit verification system (EVV) are payment in full for all services provided pursuant to this Agreement. TENNCARE shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at TCA 56-32-101 *et seq.* or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at TCA 56-51-101 *et seq.* or any subsequent amendments thereto. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

86. Section 3.3.1 shall be deleted and replaced as follows:

3.3.1 The CONTRACTOR will be paid a base capitation rate for each enrollee based on the enrollee's rate category. Rate categories are based on various factors, including the enrollee's enrollment in CHOICES, category of aid, age/sex combination and the Grand Region served by the CONTRACTOR under this Agreement. TENNCARE shall take Third Party Liability (TPL) into account in the development of capitation rates consistent with this Agreement (Section 2.21.4 and the definition of Medical Expenses described herein). This recognizes that it is the CONTRACTOR that is primarily responsible for TPL recoveries and that medical claims experience used for rate setting is net of any TPL recoveries of subrogation activities. The rate categories and the specific rates associated with each rate category are specified in Attachment XII.

87. Section 3.4 shall be amended by adding a new Section 3.4.7 and renumbering the remaining Section accordingly, including any references thereto.

3.4.7 With respect to Post Eligibility Treatment of Income (PETI), TENNCARE will perform a review of patient liability experience to determine remaining liability that had not been addressed in the managed care rate setting process. If additional adjustments are necessary, the adjustments will be made on a periodic basis to assure the correct application of federal funds.

88. Section 3.7.1 shall be amended by adding a new Section 3.7.1.7 and renumbering the existing Section accordingly, including any references thereto.

3.7.1.7 The CONTRACTOR shall, at TENNCARE's discretion and pursuant to policies or protocols established by TENNCARE, participate in a periodic capitation reconciliation process regarding CHOICES capitation payments to verify the receipt of nursing facility services or ongoing HCBS during each month that a CHOICES capitation payment was made, and to adjust the capitation payment for all months during which such services were not provided to

the member, except under specific circumstances defined by TENNCARE in policies and protocols. Such reconciliation process shall be conducted based on encounters submitted to TENNCARE by the CONTRACTOR pursuant to Section 2.23.4 of this Agreement.

89. Section 3.12 shall be deleted in its entirety and the remaining Section 3 shall be renumbered accordingly, including any references thereto.

90. The renumbered Section 3.15.1.1 shall be deleted and replaced as follows:

3.15.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed six billion, three hundred thirteen million, five hundred sixty seven thousand, two hundred eleven dollars ($6,313,567,211.00).

91. Section 4.20.2.2.7 shall be amended by adding a new Level A.32 Program Issue/Damage as follows:

A.32	Failure to ensure that a level of care (i.e., PAE) and supporting documentation submitted with the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status. (see Section 2.9.6.3.14.)		$2,000 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

92. Section 4.20.2.2.7 shall be amended by deleting and replacing the Program Issues/Damage of Level B.2, adding additional language to the Damage Section of B.21., and adding a new Level B.25 as follows:

B.2	Failure to provide a timely and acceptable corrective action plan or comply with corrective action plans as required by TENNCARE		$500 per calendar day for each day the corrective action plan is late, or for each day the CONTRACTOR fails to comply with an accepted corrective action as required by TENNCARE $2000 for failure to provide an acceptable initial corrective action plan as determined by TENNCARE in addition to $500 per calendar day from the date of notice of deficiency by TENNCARE for each day the corrective action plan remains deficient If subsequent corrective action plans are deficient, the $500 per calendar day shall continue until an acceptable plan as determined by TENNCARE is received

B.21	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17		$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% $10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% $20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% $50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% $100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement. In instances where the denominator is less than two hundred (200), TENNCARE may opt, at its discretion, to apply a $500 per occurrence assessment in lieu of the methodology described above. This per occurrence amount shall be multiplied by two (2), totaling a $1,000 per occurrence assessment when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.

B.25	Failure to meet individual Annual Quality Survey standards in subsequent years		$5000 per occurrence for repeating a deficiency(ies) in subsequent years

93. Attachments III and IV shall be amended by adding the following language to the end of the existing text:

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

94. Attachment V shall be deleted and replaced in its entirety as follows:

ATTACHMENT V

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members ---------- Travel distance does not exceed 60 miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours

Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members ---------- The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **CHILD** members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may includeSupported Employment, Illness Management & Recovery, or Peer Support	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

Amendment 13

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41

95. Attachment VI shall be amended by adding a "MCE TIP SUBMISSION FORM" as described below in front of the existing "POTENTIAL FRAUD ALLEGATION REFERRAL FORM" and "REPORT TENNCARE RECIPIENT FRAUD OR ABUSE" forms.

MCE TIP SUBMISSION FORM

related to

POTENTIAL PROVIDER FRAUD and PATIENT SAFETY

(template with sample data)

DATE: Month/Day/Year

TO: TBI, Medicaid Fraud Control Unit (MFCU)
TennCare, Office of Program Integrity

FROM: Your MCE Name

Contact Person: 1st & Last name; Telephone; EMail;

SOURCE OF TIP(s):
HOTLINE

INFORMATION OF TIP(s):
ABC Clinic, John Smith MD, Family Practice

Describtion of allegation of wrong doing: (example: Dr Smith is being reviewed for upcoding E&M)

MCE CONTRACT PERSON ON THE TIP(s):
JOHN DOW

TennCare Recommended MCC TIP/Referral Protocol:

1) The submission of documents related to the provider fraud and abuse referral should be via TennCare SFTP server **(path: tncare.sftp.state.tn.us/tncare/MCC###/orr/OPI/in)** with password protections on Documents;
2) Concurrently, a notice of submission should be e-mailed to ProgramIntegrity.TennCare@tn.gov with a subject line stating "MCC### Notice of Referral Submission via SFTP" along with password notices on opening documents.

96. Attachment VIII shall be deleted and replaced as follows:

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the TennCare Bureau unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Policies and procedures for patient liability that ensure compliance with Section 2.6.7.2

6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3

7. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.4

8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6

9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7

10. Population Health program policies and procedures that ensure compliance with Section 2.8

11. Service coordination policies and procedures that ensure compliance with Section 2.9.1

12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3

14. Transition of care policies and procedures that ensure compliance with Section 2.9.4

15. Care coordination policies and procedures that ensure compliance with Section 2.9.6

16. Policies and procedures for consumer direction of eligible CHOICES HCBS that ensure compliance with Section 2.9.7

17. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section 2.9.9

18. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.9.2 to ensure compliance with Section 2.9.9

19. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.10

20. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.11

21. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.12

22. Identification of members serving on the claims coordination committee in accordance with Section 2.9.12.5.3

23. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.13

24. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.16

25. Policies and procedures regarding non-covered services that ensure compliance with Section 2.10

26. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

27. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

28. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

29. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8

30. Policies and procedures that ensure compliance with notice requirements in Section 2.11.9

31. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.9.2

32. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

33. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.9.54)

34. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.9)

35. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.9)

36. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.10.1

37. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9

38. Information on PCP profiling as requested by TENNCARE (see Section 2.14.9)

39. QM/QI policies and procedures to ensure compliance with Section 2.15

40. Copy of signed contract with NCQA approved vendor to perform CAHPS as required by Section 2.15.5

41. Copy of signed contract with NCQA approved vendor to perform HEDIS audit as required by Section 2.15.5

42. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.5.1)

43. HEDIS BAT as required by Section 2.15.6

44. Copy of signed NCQA survey contract as required by Section 2.15.5.1

45. Notice of date for ISS submission and NCQA on-site review as required by Section 2.15.5.1

46. Notice of final payment to NCQA as required by Section 2.15.5.1

47. Notice of submission of ISS to NCQA as required by Section 2.15.5.1

48. Copy of completed NCQA survey and final report as required by Section 2.15.5.1

49. Notice of any revision to NCQA accreditation status

50. Policies and procedures regarding critical incident management and reporting to ensure compliance with Section 2.15.7.1

51. Policies and procedures regarding behavioral health adverse occurrence reporting to ensure compliance with Section 2.15.7.2

52. Report critical incidents or adverse occurrences to TENNCARE within twenty-four (24) hours pursuant to Sections 2.15.7.1, 2.15.7.2, and 2.15.7.3

53. Provider Preventable Conditions Reporting (see Section 2.15.8)

54. If applicable, information on the use of the name of the CONTRACTOR's TennCare MCO pursuant to Section 2.16.3

55. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletters, identification card, and provider directory along with any required supporting materials

56. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

57. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

58. Provider service and phone line policies and procedures that ensure compliance with Section 2.18.4

59. Description of 24/7 ED Assistance Line (see Section 2.18.4.7)

60. Provider handbook that is in compliance with requirements in Section 2.18.5

61. Provider education and training plan and materials that ensure compliance with Section 2.18.6

62. Provider relations policies and procedures in compliance with Section 2.18.7

63. Protocols regarding one-on-one assistance to long-term care providers that ensure compliance with Section 2.18.7.2

64. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.3)

65. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

66. FEA education and training plan and materials that ensure compliance with Section 2.18.9

67. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.10

68. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

69. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

70. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

71. Fraud and abuse compliance plan (see Section 2.20.3)

72. A risk assessment annually and "as needed" (see Section 2.20.3.2.2)

73. TPL policies and procedures that ensure compliance with Section 2.21.4

74. Accounting policies and procedures that ensure compliance with Section 2.21.7

75. Proof of insurance coverage (see Section 2.21.8)

76. Executed agreement for audit accounts that contains the required language (see Section 2.21.11)

77. Claims management policies and procedures that ensure compliance with Section 2.22

78. Internal claims dispute procedure (see Section 2.22.5)

79. EOB policies and procedures to ensure compliance with Section 2.22.8

80. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

81. Proposed approach for remote access in accordance with Section 2.23.6.10

82. Information security plan as required by Section 2.23.6.11

83. Notification of Systems problems in accordance with Section 2.23.7

84. Systems Help Desk services in accordance with Section 2.23.8

85. Notification of changes to Systems in accordance with Section 2.23.9

86. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

87. Notification of changes to membership of CHOICES Advisory Group and current membership lists in accordance with Section 2.24.3

88. An abuse and neglect plan in accordance with Section 2.24.4

89. Medical record keeping policies and procedures that ensure compliance with Section 2.24.6

90. Subcontracts (see Section 2.26)

91. HIPAA policies and procedures that ensure compliance with Section 2.27

92. Notification of breach and provisional breach in accordance with Section 2.27

93. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27

94. Non-discrimination policies and procedures as required by Section 2.28

95. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

96. Changes to key staff as required by Section 2.29.1.2

97. Staffing plan as required by Section 2.29.1.8

98. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.9

99. Background check policies and procedures that ensure compliance with Section 2.29.2.1

100. List of officers and members of Board of Directors (see Section 2.29.3)

101. Changes to officers and members of Board of Directors (see Section 2.29.3)

102. Eligibility and Enrollment Data (see Section 2.30.2.1)
103. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)
104. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)
105. Information on members (see Section 2.30.2.4)
106. Annual Community Outreach Plan (see Section 2.30.3)
107. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)
108. Post-Discharge Services Report (see Section 2.30.4.2)
109. Behavioral Health Crisis Response Report (see Section 2.30.4.3)
110. TENNderCare Report (see Section 2.30.4.4)
111. Population Health Update Report (see Section 2.30.5.1)
112. Population Health Report (see Section 2.30.5.2)
113. Population Health Program Description (see Section 2.30.5.3)
114. Status of Transitioning CHOICES Member Report (see Section 2.30.6.2)
115. CHOICES Nursing Facility Diversion Activities Report (see Section 2.30.6.3)
116. CHOICES Nursing Facility to Community Transition Report (see Section 2.30.6.4)
117. CHOICES HCBS Late and Missed Visits Report (see Section 2.30.6.5)
118. CHOICES Consumer Direction of eligible CHOICES HCBS Report (see Section 2.30.6.6)
119. CHOICES Care Coordination Report (see Section 2.30.6.7)
120. Monthly CHOICES Caseload and Staffing Ratio Report (see Section 2.30.6.8)
121. Quarterly MFP Participants Report (see Section 2.30.6.9)
122. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.10)
123. Pharmacy Services Report (see Section 2.30.6.11)
124. Pharmacy Services Report, On Request (see Section 2.30.6.12)
125. Provider Enrollment File (see Section 2.30.8.1)
126. Provider Compliance with Access Requirements Report (see Section 2.30.8.2)

127. PCP Assignment Report (see Section 2.30.8.3)

128. Report of Essential Hospital Services (see Section 2.30.8.4)

129. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness (see Section 2.30.8.5)

~~130. Quarterly Behavioral Health Appointment Timeliness Summary Report (see Section 2.30.8.6)~~

131. CHOICES Qualified Workforce Strategies Report (see Section 2.30.8.7)

132. FQHC Reports (see Section 2.30.8.8)

133. Related Provider Payment Report (see Section 2.30.10.1)

134. Check Run Summaries Report (see Section 2.30.10.2)

135. Claims Data Extract Report (see Section 2.30.10.3)

136. Reconciliation Payment Report (see Section 2.30.10.4)

137. Administrative Services Only Invoice Report (See Section 2.30.10.5)

138. UM program description, work plan, and evaluation (see Section 2.30.11.1)

139. Cost and Utilization Reports (see Section 2.30.11.2)

140. Cost and Utilization Summaries (see Section 2.30.11.3)

141. Identification of high-cost claimants (see Section 2.30.11.4)

142. CHOICES Utilization Report (see Section 2.30.11.5)

143. Referral Provider Listing and supporting materials (see Section 2.30.11.6)

144. Emergency Department Threshold Report (see Section 2.30.11.7)

145. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.12.1)

146. Report on Performance Improvement Projects (see Section 2.30.12.2)

147. NCQA Accreditation Report (see Section 2.30.12.3)

148. NCQA revaluation of accreditation status based on HEDIS scores (see Section 2.30.12.4)

149. Medicaid HEDIS measures marked as "Not Reported" (see Section 2.30.12.5)

150. Reports of Audited HEDIS Results (see Section 2.30.12.6)

151. Reports of Audited CAHPS Results (see Section 2.30.12.7)

152. CHOICES HCBS Critical Incidents Report (see Section 2.30.12.8)

153. Behavioral Health Adverse Occurrences Report (see Section 2.30.12.9)

154. Member Services, Provider Services, and Utilization Management Phone Line Report (see Section 2.30.13.1.1)

155. ~~24/7 Nurse Triage Line Report (see Section 2.30.13.1.2)~~

156. ED Assistance Tracking Report (see Section 2.30.13.1.3)

157. Provider Satisfaction Survey Report (see Section 2.30.13.3)

158. CHOICES Provider Satisfaction Survey Report (see Section 2.30.13.4)

159. Member Complaints Report (see Section 2.30.14)

160. Fraud and Abuse Activities Report (see Section 2.30.15.1)

161. Policies in compliance with Section 1902(a)(68) of the Social Security Act (see Section 2.30.15.3)

162. Disclosure Submission Rate Report (see Section 2.30.15.4)

163. Program Integrity Exception List Report (see Section 2.30.15.5)

164. List of Involuntary Terminations Report (see Section 2.30.15.6)

165. Recovery and Cost Avoidance Report (see Section 2.30.16.1.1)

166. Other Insurance Report (see Section 2.30.16.1.2)

167. Medical Loss Ratio (MLR) Report (see Section 2.30.16.2.1)

168. Ownership and Financial Disclosure Report (see Section 2.30.16.2.2)

169. Annual audit plan (see Section 2.30.16.2.3)

170. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.16.3.1)

171. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.16.3.2)

172. Annual Financial Report (to TDCI) (see Section 2.30.16.4.3)

173. Quarterly Financial Report (to TDCI) (see Section 2.30.16.3.4)

174. Audited Financial Statements (to TDCI) (see Section 2.30.16.3.5)

175. Claims Payment Accuracy Report (see Section 2.30.17.1)

176. EOB Report (see Section 2.30.17.2)

177. Claims Activity Report (see Section 2.30.17.3)

178. CHOICES Cost Effective Alternatives Report (see Section 2.30.17.4)

179. Systems Refresh Plan (see Section 2.30.18.1)

180. ~~Encounter Data Files (see Section 2.30.18.2)~~

181. Electronic version of claims paid reconciliation (see Section 2.30.18.3)

182. Encounter/MLR Reconciliation Report (see Section 2.30.18.4)

183. Information and/or data to support encounter data submission (see Section 2.30.18.5)

184. Systems Availability and Performance Report (see Section 2.30.18.6)

185. Business Continuity and Disaster Recovery Plan (see Section 2.30.18.7)

186. Reports on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee (see Section 2.30.19.1)

187. Report on the Activities of the CONTRACTOR's CHOICES Advisory Group (see Section 2.30.19.2)

188. Subcontracted claims processing report (see Section 2.30.20.1)

189. HIPAA/HITECH Report (*Privacy/Security Incident Report*) (see Section 2.30.21)

190. Non-discrimination policy (see Section 2.30.22.1)

191. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.22.2)

192. Non-Discrimination Compliance Report (see Section 2.30.22.3)

193. Disclosure of conflict of interest (see Section 2.30.23.1)

194. Attestation Re: Personnel Used in Contract Performance (see Section 2.30.23.2)

195. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1

196. Return of funds in accordance with Section 3.15.5

197. Termination plan in accordance with Section 4.4.8.2.8

198. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI

199. NEMT Reports (see Section A.19 of Attachment XI)

97. Section A.1 of Attachment XI shall be amended by adding a new Section A.1.3 as follows:

A.1.3 The CONTRACTOR shall develop and submit to the Bureau of TennCare for approval, a policy addressing No-Shows which limits the amount of trips a member can take when the CONTRACTOR has determined that the member has missed scheduled trips for NEMT services for a designated number of trips. Upon the approval of these policies by the Office of Contract Compliance, the CONTRACTOR shall assure all policies are implemented and followed by their NEMT brokers and their providers.

98. Section A.3.1 of Attachment XI shall be amended by adding additional language to the end of the existing text as follows:

A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member's DCS liaison, foster parent, adoptive parent, or provider. For members enrolled in an HCBS waiver for persons with Intellectual Disabilities, the member's Independent Support Coordinator/Case Manager or the member's residential or day services provider may make requests for NEMT services, even when the member's residential or day services provider is also a the contract provider that will deliver the NEMT services to the member.

99. Section A.4.2 of Attachment XI shall be deleted and replaced as follows:

A.4.2 Verifying Eligibility for NEMT Services

A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:

A.4.2.2 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR's MCO;

A.4.2.3 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment);

A.4.2.4 That the enrollee is eligible in accordance with policies and procedures approved by the Office of Contract Compliance regarding No-Shows; and

A.4.2.5 That the transportation is a covered NEMT service (see Section 2.6.1.3 of the Agreement).

100. Section A.4.6 of Attachment XI shall be deleted and replaced as follows:

A.4.6 Validating Requests

A.4.6.1 The CONTRACTOR shall conduct random pre-transportation validation checks prior to approving the request in order to prevent fraud and abuse. The amount validated shall be two percent (2%) of NEMT scheduled trips per month.

A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.

A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.

A.4.6.4 Focus of the Pre-Validations shall be, but may not be limited to, members who utilize NEMT services frequently but do not have standing orders as well as members who routinely do not adhere to the seventy-two (72) hour notice requirement.

A.4.6.5 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.4 of this Attachment.

101. Section A.5.1 of Attachment XI shall be amended by adding a new Section A.5.1.2 as follows and renumbering the remaining Section accordingly, including any references thereto.

A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider (see A.5.3 for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities).

102. Section A.5.3 of Attachment XI shall be deleted and replaced as follows:

A.5.3 **Choice of NEMT Provider**

Except for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities, the CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member's request to have or not have a specific NEMT provider or driver. If an HCBS waiver participant's residential or day services waiver provider is enrolled with the CONTRACTOR as an NEMT provider (pursuant to A.12.5), the CONTRACTOR shall permit the residential or day services waiver provider to provide medically necessary, covered NEMT services for waiver participants receiving HCBD ID waiver services from the provider, so long as the provider is able to provide the appropriate mode and level of service in a timely manner.

103. Section A.5.4 of Attachment XI shall be deleted and replaced as follows:

A.5.4 Notifying Members of Arrangements

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.4 of this Attachment) and prior to the date of the NEMT service. Responsibility of determining whether transportation arrangements have been made shall not be delegated to the member. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

104. Section A.5.5.1 of Attachment XI shall be amended by adding a new sentence to the end of the existing language as follows:

A.5.5.1 The CONTRACTOR shall provide a trip manifest to the NEMT provider of all new trips requested prior to 5 p.m. on the same business day.

105. Section A.5.5.4 of Attachment XI shall be amended by deleting the word "or" and replacing it with the word "and" as follows:

A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone and electronically to confirm that the trip will be accepted.

106. Section A.5.7 of Attachment XI shall be amended by adding a new second sentence in the middle of existing language as follows:

A.5.7 Urgent Trips

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. Trip mileage does not determine if a trip is urban or non-urban. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

107. Section A.5.10.1.2 of Attachment XI shall be amended by deleting and replacing the word "category" with the word "level".

108. Section A.7.1 of Attachment XI shall be amended by adding additional language to the end of the existing text as follows:

A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits.

109. Section A.8.2.1 of Attachment XI shall be amended by adding a new sentence to the end of the existing text as follows:

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training. Proof of all required training shall be maintained as to allow for unscheduled file audits.

110. Section A.8.3.6 through A.8.3.8 and Section A.8.3.11 of Attachment XI shall be deleted and replaced as follows:

A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers. Proof of exams shall be maintained in the driver file as to allow for unscheduled file audits.

A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol or drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. Each driver must have at least one (1) random drug and alcohol test per year. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers. Results of drug and alcohol testing shall be maintained in the driver's file as to allow for unscheduled file audits.

A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. In addition, the CONTRACTOR shall ensure that random national criminal background checks are conducted. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement. Results of background checks shall be maintained in the drivers file as to allow for unscheduled file audits.

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry or the equivalent registry in the state of the driver's residence prior to providing services under the Agreement and every year thereafter. This is in addition to the criminal background check and results shall be maintained in the driver's file as to allow for unscheduled file audits.

111. Section A.8.3.12 of Attachment XI shall be amended by adding the phrase "and annually thereafter" and Section A.8.3.12.5 shall be amended by deleting and replacing the phrase "thirty six (36)" with "twelve (12)" as follows:

A.8.3.12 The CONTRACTOR shall ensure that drivers pass a national driver license background check prior to providing services under the Agreement and annually thereafter. This initial national driver license background check shall, at a minimum, show the following:

A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous twelve (12) months;

112. Section A.8.3.13 through A.8.3.13.6 of Attachment XI shall be deleted in its entirety and the remaining Section shall be renumbered as appropriate, including any references thereto.

113. The renumbered Section A.8.3 of Attachment XI shall be amended by adding a new Section A.8.3.17 as follows:

A.8.3.17 Proof of compliance of each driver requirement shall be maintained in the driver file as to allow for unscheduled file audits.

114. Section A.9.3 of Attachment XI shall be deleted and replaced as follows:

A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for example, in Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.

115. Section A.9.4 of Attachment XI shall be amended by adding new language to the end of the existing text as follows:

A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an afterhours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message utilizing a process in which all messages are returned within (3) three hours and efforts continue until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

116. Section A.9.7 of Attachment XI shall be amended by deleting A.9.7.1 in its entirey and renumbering the remaining Section accordingly, including any references thereto and the renumbered Section A.9.7.1 shall be amended by deleting and replacing the phrase "ninety percent (90%)" with "eighty-five percent (85%)".

117. Section A.9.8 of Attachment XI shall be amended by adding additional language to the end of existing text as follows:

A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call within three (3) hours and continue the effort until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

118. Section A.9.12 of Attachment XI shall be amended by inserting the word "healthcare" in between the words "provider" and "queue" as follows:

A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider healthcare queue.

119. Sections A.9.14 of Attachment XI shall be amended by adding the word "healthcare" in front of the word "providers" as follows:

A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member's eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, healthcare providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by TENNCARE.

120. Section A.10.2 shall be deleted and replaced as follows:

A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, Standing Orders, and No-Show policies.

121. Section A.12.5 of Attachment XI shall be deleted and replaced as follows:

A.12.5 Notwithstanding an adequate network of providers or anything in this Agreement to the contrary, the CONTRACTOR shall provide Department of Intellectual and Developmental Disabilities (DIDD) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide DIDD waiver transportation services (either as an individual transportation service or as a component of residential and/or day services) pursuant to provider qualifications applicable for such providers which shall be determined by DIDD. These providers shall only provide covered NEMT services to members receiving HCBS DIDD waiver services from the provider The CONTRACTOR shall reimburse these providers for covered NEMT to TENNCARE covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided though a HCBS DIDD waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

122. Section A.13.3 of Attachment XI shall be amended by adding a new Section A.13.3.9 as follows:

A.13.3.9 Require the NEMT provider to comply with all of the CONTRACTOR's NEMT policies and procedures, including but not limited to those policies regarding No-Shows.

123. Section A.13 of Attachment XI shall be amended by adding a new Section A.13.5 and renumbering the remaining Section accordingly, including any references thereto.

A.13.5 The CONTRACTOR shall develop and implement, subject to prior approval by TENNCARE, a template provider agreement specifically for DIDD waiver residential or day services provider which reflects only those NEMT requirements that are applicable to such providers, as may be further clarified by TENNCARE in policy or protocol.

124. Section A.14.3.1 of Attachment XI shall be deleted and replaced as follows:

A.14.3.1 The CONTRACTOR shall conduct post validation checks by matching NEMT billed claims to Healthcare provider billed claims validating two percent (2%) of NEMT claims received in a month and if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before approving the requested trip (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement.

125. Section A.17.6.1 of Attachment XI shall be deleted and replaced in its entirety.

A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all NEMT providers' vehicles prior to the implementation of NEMT requirements in this Attachment. Thereafter, the CONTRACTOR shall conduct a comprehensive inspection of all vehicles at least annually. The CONTRACTOR is not required to inspect fixed route vehicles, invalid vehicles, ambulances, DIDD residential or day services providers enrolled to provide NEMT for the waiver participants they serve, or vehicles for NEMT providers with which the CONTRACTOR does not have a provider agreement (see Section A.13.2 of this Attachment).

126. Section A.19 of Attachment XI shall be deleted and replaced as follows:

A.19 NEMT REPORTING

A.19.1 Approval and Utilization Reports

A.19.1.1 Approval Report. The CONTRACTOR shall submit a quarterly approval report that summarizes transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by month and mode of transportation.

A.19.1.2 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the number of pick-ups that were late by a NEMT provider, and drop-offs where the member either missed or was late to an appointment and provides the average amount of time that the pick-ups or drop-offs were late.

A.19.1.3 Utilization Report. The CONTRACTOR shall submit a monthly utilization report that provides a summary of information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation: the number of trips, number of unduplicated members, and number of miles.

A.19.2 NEMT Call Center Reports

A.19.2.1 The CONTRACTOR shall submit a monthly report that provides a summary and detail statistics on the NEMT Call Center telephone lines/queues and includes calls received, calls answered, total calls received during regular business hours and total calls received after business hours.

A.19.2.2 The CONTRACTOR shall submit a monthly report listing the name, position title and the identification code for all members of the call center staff.

A.19.3 NEMT Provider Enrollment File

The CONTRACTOR's monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE within timeframes described below:

A.19.3.1 Driver Roster. The CONTRACTOR shall provide a monthly driver roster for each NEMT provider that includes, at minimum: the driver's name, license number, and social security number.

A.19.3.2 Vehicle Listing. The CONTRACTOR shall provide a monthly vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle's manufacturer, model, model year, and vehicle identification number.

A.19.3.3 NEMT Provider Listing. The CONTRACTOR shall provide a monthly provider listing, identifying the providers utilized during the reporting period listing the name, whether the provider is a participating or non-participating provider, mode of transportation and the county and state of the pick-up location. This report shall give the number of participating and non-participating providers as well as a grand total of all NEMT providers.

A.19.4 NEMT Claims Management Reports

A.19.4.1 The CONTRACTOR shall submit a monthly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.

A.19.4.2 The CONTRACTOR shall submit a monthly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all "processed or paid" NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month.

A.19.5 NEMT Quality Assurance and Monitoring Reports

A.19.5.1 Member NEMT Complaint Report. The CONTRACTOR shall submit a monthly member complaints report (see Section 1 of the Agreement for the definition of complaint, which includes both written and verbal statements) that details the date which the complaint was reported, the date the issue occurred, who reported the complaint, the members name, transportation provider, complaint details, date of resolution and detail of the resolution. This report shall detail complaints received about the NEMT provider.

A.19.5.2 NEMT Provider Complaint Report. The CONTRACTOR shall submit a monthly NEMT provider complaints report that details the number of verbal and written complaints from the transportation provider about a member.

A.19.5.3 NEMT Quality Assurance Plan. As part of its annual QM/QI reporting required by the Agreement, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).

A.19.5.4 NEMT Validation Checks.

A.19.5.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR,.

A.19.5.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR,.

A.19.5.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.

A.19.5.6 Accidents and Incidents.

A.19.5.6.1 Immediately upon the CONTRACTOR or the subcontracted vendor becoming aware of any accident resulting in driver or passenger injury or fatality or incidents involving abuse or alleged abuse by the driver that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident/incident report within five (5) business days of the accident/incident and shall cooperate in any related investigation. A police report shall be included in the accident/incident report or provided as soon as possible.

A.19.5.6.2 The CONTRACTOR shall submit a monthly report of all accidents, moving traffic violations, and incidents.

A.19.5.6.3 Failure by the CONTRACTOR to comply with Section A.19.5.6 shall result in the application of liquidated damages as described in Exhibit F.

A.19.5.7 Monitoring Plan.

A.19.5.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).

A.19.5.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.

A.19.5.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

127. Exhibit A of Attachment XI shall be amended by adding a new sentence to the end of the renumbered Item 18 and adding new Definitions for the terms "Urban Trip" and Non-Urban Trip" as follows:

10. Non-Urban Trip: Covered NEMT service not within a city and considered less populated, (rural as described by the US Census Bureau).

17. Urban Trip: Covered NEMT service within a city or a more populated area (not rural as described by the US Census Bureau)

18. Urgent Trip: Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital as well as a Crisis Stabilization Unit discharge shall be an urgent trip.

128. The PERFORMANCE STANDARD/LIQUIDATED DAMAGE Chart in Exhibit F of Attachment XI shall be deleted and replaced as follows:

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
1	Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)		$500 per deficiency
2	Comply with the approval and scheduling timeframes (see Section A.5.1.3 of this Attachment)		$1,000 per deficiency
3	Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)		$1500 per deficiency
4	Comply with pick-up and delivery standards (see Section A.6 of this Attachment)		$500 per deficiency

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
5	Comply with vehicle standards (see Section A.7 of this Attachment)		$1,000 per calendar day per vehicle that is not in compliance with ADA requirements $1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement $2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants $500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience $100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)		$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards
7	85% of all calls to the NEMT Call Center are answered by a live voice within thirty (30) seconds (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each full percentage point below 85% per month per line/queue For the second deficiency: $10,000 for each full percentage point below 85% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point below 85% per month per line/queue
8	Less than 5% of calls to the NEMT Call Center are abandoned (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each full percentage point above 5% per month per line/queue For the second deficiency: $10,000 for each full percentage point above 5% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point above 5% per month per line/queue

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
9	Average hold time for calls to the NEMT Call Center is no more than 3 minutes (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each 10 seconds over 3 minutes per month per line/queue For the second deficiency: $10,000 for each 10 seconds over 3 minutes per month per line/queue For the third and subsequent deficiencies: $15,000 for each 10 seconds over 3 minutes per month per line/queue
10	Process 90% of clean NEMT claims within thirty (30) calendar days of the receipt of the claim and process 99.5% of claims within sixty (60) calendar of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)		$10,000 for each month determined not to be in compliance
11	97% of NEMT claims are paid accurately upon initial submission (see Section A.15.5 of this Attachment)		$5,000 for each full percentage point accuracy is below 97% for each quarter
12	Failure by the CONTRACTOR to notify TENNCARE of an Accident/Incident in accordance with Section A.19.5.6 of this Attachment		$1000 per occurrence

129. Attachment XII shall be amended by deleting and replacing EXHIBIT G and adding a new EXHIBIT H as follows:

EXHIBIT G
CAPITATION RATES
MIDDLE
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 580.21
	Age 1 - 13	$ 96.79
	Age 14 - 20 Female	$ 237.27
	Age 14 - 20 Male	$ 144.69
	Age 21 - 44 Female	$ 399.51
	Age 21 - 44 Male	$ 251.34
	Age 45 – 64	$ 418.83
	Age 65 +	$ 484.02
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 87.13
	Age 14 - 19 Female	$ 121.42
	Age 14 – 19 Male	$ 127.39
Disabled	Age < 21	$ 1,374.26
	Age 21 +	$ 996.91
Duals/Waiver Duals	All Ages	$ 218.65
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

EXHIBIT H
CAPITATION RATES
MIDDLE
UnitedHealthCare
EFFECTIVE January 1, 2012

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 578.51
	Age 1 - 13	$ 96.35
	Age 14 - 20 Female	$ 235.93
	Age 14 - 20 Male	$ 143.93
	Age 21 - 44 Female	$ 397.23
	Age 21 - 44 Male	$ 250.00
	Age 45 – 64	$ 416.37
	Age 65 +	$ 482.23
Uninsured/Uninsurable	Age Under 1	$ 578.03
	Age 1 - 13	$ 86.69
	Age 14 - 19 Female	$ 120.59
	Age 14 – 19 Male	$ 126.84
Disabled	Age < 21	$ 1,365.38
	Age 21 +	$ 990.79
Duals/Waiver Duals	All Ages	$ 215.96
CHOICES Rate	CHOICES Duals	$ 3,991.51
	CHOICES Non-Duals	$ 5,578.98

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, 2013.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A. Emkes/cb
Mark Emkes
Commissioner

DATE: 12/17/2012

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

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

DATE: 12-13-12 JP

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, Brian Kelsey, Ken Yager, Eric Stewart
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Curtis Johnson, Vice-Chairman
Representatives
Tommie Brown, David Shepard, Jim Coley, Tony Shipley, Charles Curtiss, Curry Todd, Johnny Shaw, Mark White
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

TO: The Honorable Mark Emkes, Commissioner
Department of Finance and Administration

FROM: Senator Bill Ketron, Chairman
Representative Curtis Johnson, Vice-Chairman

DATE: June 7, 2012

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 6/4/12)

RFS# 318.66-051 (Edison # 29634)
Department: Finance and Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment adds requirements regarding the implementation and operation of CHOICES 3; adds reporting and Program Integrity language; and adds subcontract requirements.
Current maximum liability: $5,324,361,376
Proposed maximum liability: $5,324,361,376
After review, the Fiscal Review Committee voted to recommend approval of the contract amendment.

cc: The Honorable Darin Gordon, Deputy Commissioner
Ms. Jessica Robertson, Chief Procurement Officer

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

April 27, 2012

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Bureau of TennCare Managed Care Organization Contract Amendments (7)
Keystone Peer Review, Inc. (KePro) Amendment #3
Public Consulting Group, Inc., Amendment #2

Dear Mr. Geise:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments. The managed care contracts provide medical and behavioral health services to TennCare enrollees. The proposed amendment provides requirements for the Contractor regarding: (1) the implementation and operation of CHOICES Group 3, the portion of the CHOICES program that extends limited Home and Community Based Services (HCBS) benefits to individuals at risk of nursing facility placement. CHOICES Group 3 was not implemented with CHOICES Groups 1 and 2 due to the Maintenance of Effort (MOE) requirements included in the Affordable Care Act. Since that time, CMS and the State have identified a strategy that allows the State to implement CHOICES Group 3 and be in compliance with the MOE requirements until they expire on January 1, 2014; (2) language to clarify that Quality Management/Quality Improvement reporting must be specific to TennCare and not combined with other state or commercial programs; (3) Program Integrity (PI) language to clarify PI Investigators be designated by plan; (4) Social Security Administration (SSA) Data Security language added in accordance with our agreement with SSA, and (5) Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. These amendments do not represent an increase in contract funding.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-28
AMERIGROUP Tennessee, Inc.	FA-07-16936-12
UnitedHealthCare Plan of the River Valley, Inc.	FA-07-16937-12
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-09
Volunteer State Health Plan (West Region)	FA-08-24978-09

UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-09
Volunteer State Health Plan (East Region)	FA-08-24983-09

Additionally, we are submitting amendment #3 to the existing contract with Keystone Peer Review, Inc. KePro is the competitively procured contract for the provision of TennCare's recipient appeals process and is being amended to extend the term for an additional four (4) month period of time and provide funding to support this term extension. This competitively procured contract monitors a TennCare recipient-appeals process that fully complies with constitutional due process for TennCare recipients as well as complies with applicable state and federal laws. The Bureau of TennCare has prepared an RFP to competitively identify a contractor to assume the duties of this contract, however, due to federal requirements recently received that impact the structure of the RFP and services of the resulting contract, TennCare has a need to extend the current contract with KePro to provide sufficient time to include all appropriate language in the new RFP. The rates that were submitted by KePro in their original Cost Proposal will still be in effect for this short term extension.

Finally, we are submitting amendment #2 to Public Consulting Group, Inc. The State is amending this competitively-procured contract to provide additional funding for policy and operational consulting services regarding health insurance exchanges and for making evidence-based recommendations to the State. The State has received additional planning funds to analyze evolving federal guidance regarding the exchange marketplaces. Because of the continuing policy changes at the federal level and the magnitude of the market impacts in Tennessee, we sought additional planning funds (which we were awarded in November, 2011 and February, 2012), and we now need the corresponding technical assistance to analyze the emerging issues in the market and revise our recommendations if and as appropriate.

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

Sincerely,

Casey Dungan
Chief Financial Officer

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	29634	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	12
Proposed Amendment Effective Date: *(if applicable)*	July 1, 2012
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	April 30, 2012
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$5,324,361,376.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00
FY: 2013					
$989,205,835.00					

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$615,759,967.55

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	N/A

Supplemental Documentation Required for Fiscal Review Committee

reasons and explain how funding was acquired to pay the overage:				
*Contract Funding Source/Amount:	State:	$1,726,441,032.00	Federal:	$3,597,920,344.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.

Supplemental Documentation Required for Fiscal Review Committee

Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.
Amendment #10 – January 1, 2012	Program Integrity Updates, HIPAA/HITECH clarifications; CHOICES updates; Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; Increase funding to support the services for this contract for FY '12 and FY '13 based on actual expenditures
Amendment #11 – March 1, 2012	Added language to clarify that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility.
Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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).

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.

Supplemental Documentation Required for Fiscal Review Committee

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.

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 -- 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

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

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

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

ATTACHMENT X

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

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

125. **Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".**

126. **Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".**

127. **Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:**

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

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

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

UnitedHealthCare Plan (Americhoice) - Middle
FY 2012

Unit	Voucher ID	Vendor ID		Amount Pd	Pymnt Date
31865	00357932	0000021799	$	80,164,116.78	8/1/2011
31865	00357935	0000021799	$	1,749.12	8/1/2011
31865	00373132	0000021799	$	66,259,994.41	9/2/2011
31865	00373135	0000021799	$	4,290.68	9/2/2011
			$	146,430,150.99	
31865	00390204	0000021799	$	68,500,422.24	10/7/2011
31865	00390207	0000021799	$	1,970.72	10/7/2011
31865	00396234	0000021799	$	16,338,030.88	10/17/2011
31865	00396235	0000021799	$	189,155.42	10/17/2011
31865	00404008	0000021799	$	77,882,668.64	11/4/2011
31865	00404011	0000021799	$	1,159.98	11/4/2011
31865	00417176	0000021799	$	66,848,857.76	12/5/2011
31865	00417179	0000021799	$	37.42	12/5/2011
			$	229,762,303.06	
31865	101519377	0000021799	$	76,652,274.04	1/6/2012
31865	101547443	0000021799	$	84,528,169.47	2/3/2012
31865	101574349	0000021799	$	78,374,720.09	3/2/2012
31865	101538873	0000021799	$	12,350.00	2/1/2012
			$	239,567,513.60	

FY 2012 TOTAL $ 615,759,967.65

UnitedHealthCare Plan (Americhoice) - Middle
FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL **$1,051,885,932.05**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

MCO 031 AMERICHOICE MIDDLE

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

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED

COMMISSIONER OF FINANCE & ADMINISTRATION

Request Tracking #	31866-00051
Procuring Agency	Department of Finance and Administration Bureau of TennCare
Contractor	UnitedHealthCare Plan of the River Valley, Inc.
Contract #	FA-07-16937-00
Proposed Amendment #	12
Edison ID #	29634

Contract Begin Date	August 15, 2006
Current Contract End Date *– with ALL options to extend exercised*	December 31, 2014
Proposed Contract End Date *– with ALL options to extend exercised*	December 31, 2014
Current Maximum Contract Cost *– with ALL options to extend exercised*	$ 5,324,361,376.00
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	$ 5,324,361,376.00
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	X Not Applicable ☐ Attached
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	X Not Applicable ☐ Attached
Human Resources Support *– state employee training service*	X Not Applicable ☐ Attached

Explanation Need for the Proposed Amendment

This competitively procured contract provides medical and behavioral health services to TennCare enrollees. The proposed amendment provides requirements for the Contractor regarding: (1) the implementation and operation of CHOICES Group 3, the portion of the CHOICES program that extends limited Home and Community Based Services (HCBS) benefits to individuals at risk of nursing facility placement. CHOICES Group 3 was not implemented with CHOICES Groups 1 and 2 due to the

Request Tracking #	31866-00051

Maintenance of Effort (MOE) requirements included in the Affordable Care Act. Since that time, CMS and the State have identified a strategy that allows the State to implement CHOICES Group 3 and be in compliance with the MOE requirements until they expire on January 1, 2014; (2) language to clarify that QM/QI reporting must be specific to TennCare and not combined with other state or commercial programs; (3) Program Integrity language to clarify PI Investigators be designated by plan; (4) SSA Data Security language added in accordance with our agreement with SSA, and (5) Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. No additional funding is required relative to this amendment.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to provide requirements for the Contractor regarding: (1) the implementation and operation of CHOICES Group 3, the portion of the CHOICES program that extends limited Home and Community Based Services (HCBS) benefits to individuals at risk of nursing facility placement. CHOICES Group 3 was not implemented with CHOICES Groups 1 and 2 due to the Maintenance of Effort (MOE) requirements included in the Affordable Care Act. Since that time, CMS and the State have identified a strategy that allows the State to implement CHOICES Group 3 and be in compliance with the MOE requirements until they expire on January 1, 2014; (2) language to clarify that QM/QI reporting must be specific to TennCare and not combined with other state or commercial programs; (3) Program Integrity language to clarify PI Investigators be designated by plan; (4) SSA Data Security language added in accordance with our agreement with SSA, and (5) Subcontract termination requirements added to provide an MCO with an avenue to discontinue an agreement with a company when it is in the best interest of TennCare and its enrollees. All of these elements contained in this amendment are required to enhance the medical and behavioral services provided by the Contractor for the benefit of the TennCare population.

Request Tracking #	31866-00051

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark R. Emker 4/24/12

CD

CONTRACT SUMMARY SHEET

021 10/

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-12

State Agency	State Agency Division
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- Edison Vendor #0000021792

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
TOTAL:	$ 1,726,441,032.00	$ 3,597,920,344.00	$ -	$ -	**$ 5,324,361,376.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
TOTAL:	**$ 5,324,361,376.00**	**$0.00**
End Date	December 31, 2014	December 31, 2014

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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)

FA0716937-12

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

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government (eg.IO,GG,GU) [ ] Other

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

AMENDMENT NUMBER 12
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

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

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As it relates to Interim CHOICES Group 3, open for enrollment only between July 1, 2012 and December 31, 2013, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meet Nursing Financial eligibility criteria, and also meet the Nursing Facility level of care in effect on June 30, 2012.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
   Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

2. Group 2
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

3. Group 3
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are "at-risk" for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

4. Interim Group 3 (open for new enrollment only between July 1, 2012, through December 31, 2013)
   Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of MOE Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth is this agreement regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

Consumer Direction of Eligible CHOICES HCBS – The opportunity for a CHOICES member assessed to need specified types of CHOICES HCBS including attendant care, personal care, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy. A member's individual cost neutrality cap shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care application.

Eligible CHOICES HCBS – Attendant care, personal care, in-home respite, companion care services and/or any other CHOICES HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Eligible Individual – With respect to Tennessee's Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State's approved MFP Operational Protocol and TENNCARE Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Nursing Facility (NF) or an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.

    a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

    b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

    c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., not covered by Medicare) as a cost-effective alternative (see Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.

2. Be eligible for and receive Medicaid benefits for inpatient services furnished by the nursing facility or ICF/MR for at least one (1) day. For purposes of this Agreement, an Eligible Individual must reside in a nursing facility and be enrolled in CHOICES Group 1 for a minimum of one (1) day and must be eligible to enroll and transition seamlessly into CHOICES Group 2 or CHOICES Group 3 (without delay or interruption).

3. Meet nursing facility or ICF/MR level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility or meet at-risk level of care such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to live in the community will likely deteriorate and result in the need for institutional placement.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

Long-Term Care (LTC)– The services of a nursing facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community-Based Services (HCBS). These services may also be called Long-Term Services and Supports (LTSS).

Ongoing CHOICES HCBS – Specified CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of community-based residential alternatives and PERS) on a continuous basis. Ongoing HCBS include community-based residential alternatives, personal care, attendant care, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

Qualified Institution – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/MR.

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under the Affordable Care Act.

TENNCARE PreAdmission Evaluation System (TPAES) – A_component of the State's Medicaid Management Information System and the system of record for all PreAdmission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTC programs, including CHOICES and the State's MFP Rebalancing Demonstration (MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) – The state agency having the authority to provide care for persons with mental illness, substance abuse, and/or developmental disabilities.

Transition Allowance – A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES Group 1 member in order to facilitate transition from a nursing facility to the community when such member will, upon transition to CHOICES Group 2, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. A Transition Allowance shall not be provided to members that no longer meet nursing facility level of care and are transitioning to CHOICES Group 3.

2. Section 1 shall be amended by adding the following new definitions:

Maintenance of Effort (MOE) – Provisions in the American Recovery and Reinvestment Act (ARRA) (Pub. L. 111–5) (Feb. 17, 2009) and the Affordable Care Act (ACA) to ensure that States' coverage for adults under the Medicaid program remains in place and that "eligibility standards, methodologies, and procedures" are not more restrictive than those in place as of July 1, 2008 for purposes of the ARRA and March 23, 2010, for purposes of the ACA pending the establishment of specific provisions of ACA (i.e., a fully operational Exchange) on January 1, 2014.

MOE Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with disabilities who (1) meet nursing home financial eligibility, (2) do not meet the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare CHOICES services, are "at risk" of institutionalization. The MOE Demonstration Group is open only between July 1, 2012, through December 31, 2013. Individuals enrolled in the MOE Demonstration Group as of December 31, 2013, may continue to qualify in this group after December 31, 2013, so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the MOE Demonstration Group and in CHOICES 3.

3. Section 2.6.1.5.2.5 shall be amended by adding the phrase "but excluding Interim Group 3," in the first sentence immediately following "3,".

2.6.1.5.2.5 For Groups 2 and 3, but excluding Interim Group 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR's request to provide CHOICES HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

Amendment 12 (cont.)

4. Section 2.6.1.5.3 and 2.6.1.5.4 shall be deleted and replaced as follows:

2.6.1.5.3 For persons determined to be eligible for enrollment in Group 2 as a result of Immediate Eligibility (as defined in Section 1 of this Agreement), the CONTRACTOR shall provide a limited package of CHOICES HCBS (personal care, attendant care, home-delivered meals, PERS, adult day care, and/or any other services as specified in TennCare rules and regulations) as identified through a needs assessment and specified in the plan of care. Upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, the CONTRACTOR shall authorize additional services in accordance with Section 2.9.6.2.5. For members residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.6.1.5.4 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X

Service and Benefit Limit	Group 1	Group 2	Group 3
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

5. **Section 2.6.5.2.5 shall be deleted and replaced as follows:**

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars ($2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items. A Transition Allowance shall not be provided to members that no longer meet nursing facility level of care and are transitioning to CHOICES Group 3.

6. **Section 2.6.5.3 shall be deleted and replaced as follows:**

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care for CHOICES Group 2 members pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for CHOICES Group 1 members who are transitioning to CHOICES Group 2, and NEMT for Groups 2 and 3.

7. **Sections 2.6.7.2.2.3 shall be amended by deleting the reference to Section "2.9.6.3" and replacing it with "2.9.6.8".**

2.6.7.2.2.3 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the member otherwise qualifies to enroll in CHOICES Group 2, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, and the CONTRACTOR is willing to continue serving a member who has failed to pay his or her patient liability or if TENNCARE determines that the member would not have patient liability in the community setting, the member shall be offered a choice of CHOICES HCBS. If the member chooses CHOICES HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding transition to Group 2 (Section 2.9.6.8).

8. Sections 2.6.7.2.3.2 through 2.6.7.2.3.2.2 shall be deleted and replaced as follows:

2.6.7.2.3.2 The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 members (as applicable) who receive CHOICES HCBS in his/her own home or who receive adult day care services and from Group 2 members who receive Companion Care.

2.6.7.2.3.2.1 The CONTRACTOR shall use calculated patient liability amounts to offset the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to covered CHOICES Group 2 or Group 3 benefits) reimbursed by the CONTRACTOR for that month.

2.6.7.2.3.2.2 The CONTRACTOR shall not collect patient liability that exceeds the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to CHOICES Group 2 or Group 3 benefits) reimbursed by the CONTRACTOR for that month.

9. Section 2.6.7.2.3.3 shall be amended by adding the phrase "or Group 3" after "If a Group 2" as follows:

2.6.7.2.3.3 If a Group 2 or Group 3 member fails to pay required patient liability, pursuant to Section 2.6.1.5.8.6, the CONTRACTOR may request to no longer provide long-term care services to the member.

10. The last sentence of Section 2.7.1.3 shall be amended by deleting the space between the word "non-emergency".

11. Sections 2.9.2.1.4.6.2 through 2.9.2.1.4.6.4 shall be deleted and replaced as follows:

2.9.2.1.4.6.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 or the member meets the at-risk level of care and is enrolled in CHOICES Group 3 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1;

2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) the member chooses to transition to a nursing facility and enroll in Group 1; or

12. Section 2.9.6.1.6.1 shall be deleted and replaced as follows:

2.9.6.1.6.1 The day of the initiating event (e.g., receipt of a referral for CHOICES screening and intake or notification of a new CHOICES member on the outbound 834 enrollment file) shall be the anchor date and is not to be included in the timeline computation;

13. Section 2.9.6.2.3.1 shall be deleted and replaced as follows:

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TennCare and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet level of care eligibility for enrollment in CHOICES; and (3) for applicants seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.

14. Section 2.9.6.2.3.4 and 2.9.6.2.3.5 shall be deleted and replaced as follows:

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) complete Medicaid and level of care (i.e., PAE) applications and provide assistance, as necessary, in gathering documentation needed by the State to determine TennCare eligibility; (4) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (5) for applicants seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (6) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; (7) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (8) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; (9) for applicants who are seeking enrollment in Group 2, identify the services that may be needed by the applicant upon enrollment in Group 2, make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the applicant regarding the individual cost neutrality cap, including that a change in a member's needs or circumstances that would result in the

cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; (10) for applicants who are seeking enrollment in Group 3, identify the covered HCBS that may be needed by the applicant upon enrollment in Group 3 and provide explanation to the applicant regarding the fifteen thousand dollars ($15,000) expenditure cap; and (11) for all applicants, provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The listing of CHOICES HCBS and home health and/or private duty nursing services the member may need shall be used by TENNCARE or its designee to determine whether services can be provided within the member's cost neutrality cap (applicable only for Group 2) and may be further refined based on the CONTRACTOR's comprehensive needs assessment and plan of care development processes.

15. Section 2.9.6.2.4.3 shall be amended by adding new language to the end of the existing language as follows:

2.9.6.2.4.3 The CONTRACTOR shall not transition members in Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2 or a member enrolled in CHOICES on or after July 1, 2012 no longer meets nursing facility level of care but does meet the at-risk level of care and is enrolled in Group 3.

16. Section 2.9.6.2.5.3 shall be amended by adding the phrase "in Group 2" after the word "enrolled" in the first sentence.

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 CHOICES HCBS, except in the case of members enrolled in Group 2 on the basis of Immediate Eligibility in which case only the limited package of CHOICES HCBS shall be authorized and initiated. Members enrolled on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES 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.

17. Sections 2.9.6.2.5.5 and 2.9.6.2.5.6 shall be deleted and replaced as follows:

2.9.6.2.5.5 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless the member meets nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; (2) chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of a Group 2 member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.2.5.6 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets nursing facility level of care in place at the time of admission and: (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) chooses to transition to a nursing facility and enroll in Group 1.

18. Section 2.9.6.3.2 shall be deleted and replaced as follows:

2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member's current eligibility category based on information provided by TENNCARE in the outbound 834 enrollment file; for persons seeking access to CHOICES HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility category, and if not, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS or MOE Demonstration) category; (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

19. Section 2.9.6.3.9 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in gathering documentation needed by DHS to determine categorical/financial eligibility for LTC; (4) for members seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (5) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for members who want to receive nursing facility

services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (8) for members seeking enrollment in Group 2, make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; (9) for members seeking enrollment in Group 3, provide explanation to the member regarding the fifteen thousand dollar ($15,000) expenditure cap; ; and (10) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

20. Section 2.9.6.3.14 shall be deleted and replaced as follows:

2.9.6.3.14 Once completed, in the manner prescribed by TENNCARE the CONTRACTOR shall submit the level of care and, for members requesting CHOICES Group 2 HCBS, documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap to TENNCARE as soon as possible but no later than five (5) business days of the face-to-face visit. The CONTRACTOR shall make every effort to obtain supporting documentation required for the level of care in a timely manner and shall document in writing the cause of any delay in the submission of the required documentation to TENNCARE, including the CONTRACTOR's actions to mitigate such delay. The CONTRACTOR shall be responsible for ensuring that the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status based on information gathered, at a minimum, from the member, his or her representative, the Care Coordinator's direct observations, and the history and physical or other medical records which shall be submitted with the application. The CONTRACTOR shall note in the level of care any discrepancies between these sources of information, and shall provide explanation regarding how the CONTRACTOR addressed such discrepancies in the level of care.

21. Section 2.9.6.3.16 shall be deleted and replaced as follows:

2.9.6.3.16 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility

services if CHOICES Group 2 HCBS are not immediately available; (3) determining whether the person wants nursing facility services if CHOICES Group 2 HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in Group 2 as a CEA (see Section 2.9.6.3.15.1).

22. Section 2.9.6.3.20 shall be deleted and replaced as follows:

2.9.6.3.20 For the CONTRACTOR's current members enrolled into CHOICES Group 2 or Group 3, the member's Care Coordinator shall within ten (10) business days of notice of the member's enrollment in CHOICES Group 2 or Group 3, authorize and initiate CHOICES HCBS.

23. Section 2.9.6.3.20.3 shall be deleted and replaced as follows:

2.9.6.3.20.3 The CONTRACTOR shall provide at least verbal notice to the member prior to initiation of CHOICES HCBS identified in the plan of care regarding any change in providers selected by the member for each CHOICES HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a CHOICES Group 1 or 2 member in the nursing facility or community-based residential alternative setting requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.

24. Sections 2.9.6.3.20.7 through 2.9.6.3.20.9 shall be deleted and replaced as follows:

2.9.6.3.20.7 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2 or a member enrolled in CHOICES on or after July 1, 2012 no longer meets nursing facility level of care but does meet the at-risk level of care and is enrolled in Group 3.

2.9.6.3.20.8 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and : (1) is expected to require a short-term nursing facility care stay for ninety (90) days or less; (2) chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.3.20.9 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and: (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) chooses to transition to a nursing facility and enroll in Group 1.

25. Section 2.9.6.4.3.2 shall be amended by deleting the reference to Section "2.9.6.3.19" and replacing it with "2.9.6.3.20".

2.9.6.4.3.2 For CHOICES members who, upon enrollment in CHOICES, are not receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific care coordinator and shall advise the member of the name of his/her care coordinator and provide contact information prior to the initiation of services (see Section 2.9.6.2.5.3 and 2.9.6.3.20), but no more than ten (10) calendar days following CHOICES enrollment.

26. Section 2.9.6.6.2.4 shall be amended by adding the phrase "in CHOICES Group 2" in items (4) and (5) as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled in CHOICES Group 2 on the basis of Immediate Eligibility who shall have access to services beyond the limited package of CHOICES HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, and the schedule at which such care is needed, as applicable; members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

27. Section 2.9.6.8 shall be deleted and replaced as follows:

2.9.6.8 Nursing Facility-to-Community Transition

2.9.6.8.1 The CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

2.9.6.8.1.1 Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;

2.9.6.8.1.2 Identification through the care coordination process, including but not limited to: assessments, information gathered from nursing facility staff, participation in Grand Rounds (as defined in Section 1) or review and assessment of members whose nursing facility level of care is ending and who appear to meet the at-risk level of care for Group 3. 2.9.6.8.1.3 Review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.

2.9.6.8.2 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are under the age of twenty-one (21) and have requested to transition home will be provided coordination of care by the CONTRACTOR's CHOICES and MCO Case Management staff (see Section 2.9.5.4.1).

2.9.6.8.3 Notwithstanding the nursing facility-to-community transition requirements set forth in this section (2.9.6.8.), the CONTRACTOR shall be responsible for monitoring all Group 1 members' level of care eligibility (see Section 2.9.6.8.1.2.) and for completing the process to re-establish nursing facility level of care or transition to Group 3 HCBS, as appropriate, prior to expiration of nursing facility level of care.

2.9.6.8.4 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral a care coordinator conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition from Group 1 to Group 2 when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.5 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification a care coordinator conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.6 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections 2.9.6.8.3 and 2.9.6.8.4 above) or within fourteen (14) days of identification through the care coordination process, the care coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.

2.9.6.8.7 As part of the transition assessment, the care coordinator shall conduct a risk assessment using a tool and protocol specified by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall begin to develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk as part of the plan of care. The risk agreement shall include the frequency and type of care coordinator contacts that exceed the minimum contacts required (see Section 2.9.6.9.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. For members transitioning to Group 2, the member's care coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator shall explain to the member the individual cost neutrality cap and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the CONTRACTOR will assist with transition to a more appropriate care delivery setting. For members transitioning to Group 3, the care coordinator shall explain the expenditure cap.

2.9.6.8.8 For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator shall notify them in accordance with the specified transition assessment protocol.

2.9.6.8.9 For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.

2.9.6.8.10 The care coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.

2.9.6.8.11 As part of transition planning, prior to the member's physical move to the community, the care coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections 2.9.6.8.19 and 2.9.6.8.20.

2.9.6.8.12 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation,

availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

2.9.6.8.13 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.2.9.6.8.14 The member's care coordinator shall also complete a plan of care that meets all criteria described in Section 2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive needs assessment, completing and signing the risk agreement and making a final determination of cost neutrality. The plan of care shall be authorized and initiated prior to the member's transition to the community.

2.9.6.8.14.1. If a transitioning member is enrolled in CHOICES Group 1, any CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., minor home modifications, adaptive equipment, or PERS installation) shall be completed while the member is enrolled in Group 1, but shall be billed as a Group 2 service once the member is enrolled into Group 2, with the date of service the effective date of enrollment in CHOICES Group 2 (see State Medicaid Director Letter, Olmstead Update No. 3, July 25, 2000).

2.9.6.8.14.2. If a transitioning member is enrolled in CHOICES Group 2 or 3 but is receiving short-term nursing facility care, any CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., minor home modifications, adaptive equipment, or PERS installation) shall be completed while the member resides in the facility and billed as a Group 2 or Group 3 service, as applicable. However, a member shall not be transitioned from CHOICES Group 1 into Group 2 or 3 for receipt of short-term nursing facility services in order to provide these services. Short-term nursing facility care is available only to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services *upon admission* to the short-term nursing facility stay.

2.9.6.8.15 For members requesting transition from Group 1 to Group 2, the CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).

2.9.6.8.16 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that for members transitioning to Group 2, the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member, the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 or Group 3, as applicable, effective as of the planned transition date.

2.9.6.8.17 Ongoing CHOICES HCBS and any medically necessary covered home health or private duty nursing services needed by the member shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2 or CHOICES Group 3) and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing CHOICES HCBS.

2.9.6.8.18 The member's care coordinator/care coordination team shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.

2.9.6.8.19 For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator/care coordination team shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care, and shall take immediate action to resolve any service gaps (see definition in Section 1).

2.9.6.8.20 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the care coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.

2.9.6.8.21 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the care coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the care coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the care coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

2.9.6.8.22 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.

2.9.6.8.23 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the care coordinator.

2.9.6.8.24 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.

2.9.6.8.25 To facilitate nursing facility to community transition, the CONTRACTOR may elect to use specialized transition coordinators or transition teams. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

2.9.6.8.26 The CONTRACTOR shall implement policies and processes necessary to ensure that it is aware when a member is admitted to or discharged from a NF in order to facilitate care planning and as seamless a transition as possible, and to ensure timely notification to TENNCARE and other entities (e.g., DHS) as appropriate.

2.9.6.8.26.1 The CONTRACTOR shall require NFs to notify the CONTRACTOR of all NF discharges, transfers between NFs, or elections of hospice services in a NF.

2.9.6.8.26.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF; b) DHS of all NF discharges and transfers between NFs; and c) receiving NFs of all applicable level of care information when a member is transferring between NFs.

2.9.6.8.26.3 The CONTRACTOR shall conduct a census as frequently as deemed necessary by TENNCARE to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.

2.9.6.8.26.4 The CONTRACTOR shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member meets the nursing facility level of care in place at the time of admission; (2) the member's stay in the facility is expected to be less than ninety (90) days; and (3) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

2.9.6.8.26.4.1 Upon request, the CONTRACTOR shall provide to TENNCARE a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, and the anticipated date of discharge back to the community.

28. Section 2.9.6.9.4.3.3 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

2.9.6.9.4.3.3 Members in CHOICES Group 2 or Group 3 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section 2.9.6.8.

29. Sections 2.9.6.9.4.3.7 through 2.9.6.9.4.3.9 shall be deleted and replaced as follows:

2.9.6.9.4.3.7 Members in CHOICES Group 2 or Group 3 shall be contacted by their care coordinator at least monthly either in person or by telephone with an interval of at least fourteen (14) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

2.9.6.9.4.3.8 Members in CHOICES Group 2 or Group 3 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member's MFP participation period, minimum contacts shall be as described in 2.9.6.9.4.3.7 unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, or based on a significant change in circumstances (see Sections 2.9.6.9.2.1.16. and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

30. Sections 2.9.6.9.6.3.3 and 2.9.6.9.6.3.4 shall be deleted and replaced as follows:

2.9.6.9.6.3.3 For members whose plan of care includes eligible CHOICES HCBS, written confirmation of the member's decision regarding participation in consumer direction of eligible CHOICES HCBS;

2.9.6.9.6.3.4 A completed risk assessment and a risk agreement signed and dated by the member or his/her representative; and

31. Section 2.9.6.11.6.1.1 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

2.9.6.11.6.1.1 Upon completion of a Transition Assessment which indicates that a Group 1 member is a candidate for transition to the community, such member shall be factored into the weighted caseload and staffing ratio calculations using an acuity level of two and one-half (2.5) until such time as the member is transitioned to CHOICES Group 2 or Group 3 or the member is no longer a candidate for transition;

32. Section 2.9.6.11.6.2 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

2.9.6.11.6.2 Each CHOICES Group 2 or Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5);

33. Sections 2.9.6.11.6.3 and 2.9.6.11.6.4 shall be amended by deleting and replacing the header of the charts as follows:

2.9.6.11.6.3. Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125:

Weighted Caseload Mix for a **1:125** Ratio		
CHOICES Group 1 (Acuity 1.0)	CHOICES Group 2 and Group 3 (Acuity 2.5)	Total CHOICES Members on Caseload
125	0	125
100	10	110
75	20	95
50	30	80
25	40	65
0	50	50

2.9.6.11.6.4. Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175:

Weighted Caseload Mix for a **1:175** Ratio		
CHOICES Group 1 (Acuity 1.0)	CHOICES Group 2 and Group 3 (Acuity 2.5)	Total CHOICES Members on Caseload
175	0	175
150	10	160
125	20	145
100	30	130
75	40	115
50	50	100
25	60	85
0	70	70

34. Section 2.9.6.11.8 shall be deleted and replaced as follows:

2.9.6.11.8 Upon request, the CONTRACTOR shall provide to TENNCARE documentation of such monitoring, including an itemized list by care coordinator of the total number of members assigned, and the number of Group 1 members (including members in transition and children under age 21), Group 2 and Group 3 members that comprise each care coordinator's caseload.

35. Section 2.9.6.11.18.1 shall be deleted and replaced as follows:

2.9.6.11.18.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, the expenditure cap for Group 3, and the limited benefit package for Group 2 members enrolled on the basis of Immediate Eligibility;

36. Section 2.9.6.11.18.17 shall be deleted and replaced as follows:

2.9.6.11.18.17 For all CHOICES members, as applicable, members' responsibility regarding patient liability, including the consequences of not paying patient liability;

37. Section 2.9.6.13.1 shall be deleted and replaced as follows:

2.9.6.13.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES), the system of record for CHOICES level of care determinations, to facilitate submission of all PreAdmission Evaluation (i.e., level of care) applications, including required documentation pertaining thereto, and to facilitate enrollments into and transitions between LTC programs, including CHOICES. The CONTRACTOR shall comply with all data entry and tracking processes and timelines established by TENNCARE in policy or protocol in order to ensure efficient and effective administration and oversight of the CHOICES program.

38. Section 2.9.7.4.1 shall be amended by deleting the reference to "Section 2.9.6.2.4" and replacing it with the reference to "Section 2.9.6.2.5" and Section 2.9.7.4.3.3 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2" and Section 2.9.7.4.3.4 shall be amended by deleting the phrase "Group 2" at the end of the sentence.

2.9.7.4.3.3 For any CHOICES Group 2 or Group 3 member electing to participate in consumer direction that refuses to receive eligible CHOICES HCBS from contract providers while services are initiated through consumer direction, the member's care coordinator shall visit the member face to face at least monthly to ensure that the member's needs are safely met, and shall continue to offer eligible CHOICES HCBS through contract providers.

2.9.7.4.3.4 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES.

39. Section 2.9.8.1.2 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

2.9.8.1.2 Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from CHOICES Group 1 into CHOICES Group 2 or Group 3 pursuant to TENNCARE policies and protocols for Nursing Facility-to-community transitions and shall also be enrolled into MFP. For persons enrolled in CHOICES who are also participating in MFP, the CONTRACTOR shall comply with all applicable provisions of this Agreement pertaining to the CHOICES program. This section sets forth additional requirements pertaining to the CONTRACTOR's responsibilities specifically as it relates to MFP.

40. Section 2.9.8.2.2 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

2.9.8.2.2 The CONTRACTOR shall assess all nursing facility residents transitioning from the NF to CHOICES Group 2 or Group 3 for participation in MFP. This includes CHOICES Group 1 members referred for transition, as well as nursing facility residents referred for CHOICES who are not yet enrolled in CHOICES Group 1 but may be determined eligible for Group 1, and who have expressed a desire to move back into the community. However, the resident must actually be enrolled into Group 1 in order to qualify for MFP.

41. Sections 2.9.8.3.3 and 2.9.8.3.4 shall be deleted and replaced as follows:

2.9.8.3.3 Only CHOICES Group 1 members who qualify to enroll in CHOICES Group 2 or Group 3 shall be eligible to transition to Group 2 or Group 3, as applicable, and enroll into MFP.

2.9.8.3.4 In addition to facilitating transition from CHOICES Group 1 to CHOICES Group 2 or Group 3 pursuant to Section 2.9.6.8 of this Agreement and TENNCARE's policies and protocols, the CONTRACTOR shall facilitate the enrollment of Eligible Individuals who consent into MFP.

42. Sections 2.9.8.4.6 and 2.9.8.4.12 shall be amended by adding the phrase "or Group 3, as applicable" after the phrase "CHOICES Group 2".

2.9.8.4.6 The CONTRACTOR shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that continued participation in CHOICES Group 2 or Group 3, as applicable, and in MFP is appropriate.

2.9.8.4.12 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice of MFP participation to each member enrolled in MFP which shall not occur prior to transition from CHOICES Group 1 to CHOICES Group 2 or Group 3, as applicable. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is enrolled in MFP.

43. Sections 2.9.8.5.1, 2.9.8.6.1, and 2.9.8.7.1 shall be amended by adding the phrase "or Group 3, as applicable" after the phrase "CHOICES Group 2".

2.9.8.5.1 For members participating in the MFP, the Plan of Care shall reflect that the member is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from CHOICES Group 1 to CHOICES Group 2 or Group 3, as applicable).

2.9.8.6.1 A member enrolled in MFP shall be simultaneously enrolled in CHOICES Group 2 or Group 3, as applicable, and shall be eligible to receive covered benefits as described in 2.6.1

2.9.8.7.1 Upon completion of a person's 365-day participation in MFP, services (including CHOICES HCBS) shall continue to be provided in accordance with the covered benefits described in 2.6.1 and the member's plan of care. Transition from participation in MFP and CHOICES Group 2 or Group 3, as applicable, to participation *only* in CHOICES Group 2 or Group 3, as applicable, shall be seamless to the member, except that the CONTRACTOR shall be required to issue notice of the member's conclusion of his 365-day MFP participation period.

44. Sections 2.9.8.8.1 and 2.9.8.8.2 shall be deleted and replaced as follows:

2.9.8.8.1 A CHOICES Group 2 or Group 3 member that meets the nursing facility level of care in place at the time of admission may be admitted for an inpatient short-term nursing facility stay for up to ninety (90) days and remain enrolled in CHOICES Group 2 or Group 3, as applicable (see Section 2.6.1.5.4). The CONTRACTOR shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time: a) it is determined that the stay will not be short-term and the member will not transition back to the community; and b) prior to exhausting the ninety (90) day short-term nursing facility benefit covered for CHOICES Group 2 or Group 3 members (see Section 2.9.6.8.26.4).

2.9.8.8.2 A CHOICES Group 2 or Group 3 member participating in MFP who meets the nursing facility level of care in place at the time of admission may be admitted for an inpatient short-term nursing facility stay during his 365-day participation period and remain enrolled in MFP regardless of the number of days the member is admitted for inpatient facility care.

45. Sections 2.9.8.8.4 shall be deleted and replaced as follows:

2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 or Group 3 if the Group 3 member continues to meet nursing facility level of care to CHOICES Group 1.

46. Sections 2.9.8.8.6 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

2.9.8.8.6 The CONTRACTOR shall conduct a Transition Assessment and develop a Transition Plan (see Section 2.9.6.8) as necessary to facilitate the member's return to the community. Such assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 and continued participation in MFP is appropriate. The CONTRACTOR shall update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.

47. Section 2.9.8.11.1 shall be amended by deleting the reference to "Section 2.9.6.12.6" and replacing it with the reference to "Section 2.9.6.12.7".

48. Section 2.9.8.13.1.5.2 shall be amended by adding the phrase "and Group 3" after the phrase "CHOICES Group 2".

2.9.8.13.1.5.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #5 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 2 and Group 3. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

49. Sections 2.9.15.1 and 2.9.15.5 shall be deleted and replaced as follows:

2.9.15.1 Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and Tennessee Department of Intellectual and Developmental Disabilities (DIDD) for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;

2.9.15.5 Tennessee Department of Intellectual Disabilities Services (DIDD), for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, i.e., mental retardation;

50. Section 2.13.4.4 shall be amended by deleting the reference to "Section 2.9.6.7" and replacing it with "Section 2.9.7.6.11".

51. Section 2.14.1.2 shall be amended by adding a new Section 2.14.1.2.1 as follows:

2.14.1.2.1 The UM program description, work plan and program evaluation shall be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.

52. Section 2.15.1.1.6 shall be amended by deleting the word "and"at the end of the sentence, Section 2.15.1.1.7 shall be amended by deleting and replacing the "." with "; and", and Section 2.15.1.1 shall be amended by adding a new Section 2.15.1.1.8 as follows:

2.15.1.1.8 The QM/QI program description, work plan and program evaluation shall be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.

53. Section 2.17.4.7.11 shall be amended by adding the phrase "(excluding Interim Group 3)" after the phrase "Group 2 and Group 3".

2.17.4.7.11 Shall include information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

54. Section 2.17.7.3.12 shall be deleted and replaced as follows:

2.17.7.3.12 Information about patient liability responsibilities including the potential consequences of failure to comply with patient liability requirements. For Group 1 members, this may include loss of the member's nursing facility provider; for Group 2 members, loss of the member's CBRA provider; and for all CHOICES members, loss of the member's MCO, disenrollment from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

55. Section 2.20.2 shall be deleted and replaced as follows:

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.

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).

2.20.2.3 The CONTRACTOR shall notify TBI MFCU and TennCare Office of Program Integrity simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (http://www.tbi.state.tn.us/tbi_tips.shtml; ProgramIntegrity.TennCare@tn.gov). Along with a notification, the CONTRACTOR shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TBI MFCU and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.

2.20.2.4 The CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.4.1 Suspected fraud and abuse in the administration of the program shall be reported to TennCare Office of Program Integrity, TBI MFCU and/or OIG;

2.20.2.4.2 All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU and TennCare Office of Program Integrity; and

2.20.2.4.3 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.

2.20.2.5 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.

2.20.2.6 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.

2.20.2.7 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:

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

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

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

2.20.2.8 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.

2.20.2.9 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.

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

2.20.2.11 The CONTRACTOR, subcontractor 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, subcontractor 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.

2.20.2.12 The CONTRACTOR and/or subcontractors 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.

2.20.2.13 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.

2.20.2.14 Except as described in Section 2.11.8.2 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.

2.20.2.15 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section 2.12.9.42).

56. Section 2.22.1 shall be amended by deleting the word "and" between the words "filing," and "compliance" and by adding new language to the end of the section.

2.22.1 **General**

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, compliance with all applicable state and federal laws, rules and regulations, including the development, staff and provider education and training, and implementation of all state and federal standardization initiatives (e.g., 5010, ICD 10, etc.) within the designated guidelines and timeframes specified by TENNCARE and/or CMS.

57. Section 2.25.9 shall be deleted in its entirety.

58. Section 2.26.1 shall be amended by adding a new Section 2.26.1.3 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.26.1.3 Effective with any new subcontracts or upon the next amendment to existing subcontracts, the CONTRACTOR shall include a requirement that the subcontract may be terminated by the CONTRACTOR for convenience and without cause upon a specified number of days written notice.

59. Section 2.29.1.3.13 shall be deleted and replaced as follows:

2.29.1.3.13 At least one full-time investigator per operating region and a staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement. The investigator will have full knowledge with provider investigations related to the TennCare program and will be the key staff handling day-to-day provider investigation related inquires from TENNCARE;

60. Section 2.29.1.3.29 shall be amended by deleting "TDMHDD" and replacing it with "TDMHSAS".

61. Section 2.30.4.3 shall be deleted and replaced as follows:

2.30.4.3 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements described by TENNCARE. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all data elements shall be reported for each individual crisis service provider as described in the template provided by TENNCARE.

62. Sections 2.30.6.4 and 2.30.6.6 shall be amended by deleting the reference to "Section 2.9.6.8" and replacing it with the reference to "Section 2.9.8" and Item (1) of Section 2.30.6.9 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2".

(1) The total number and the name and SSN of each CHOICES Group 2 or Group 3 member enrolled into MFP;

63. Sections 2.30.11.5, 2.30.12.7, and 2.30.17.5 shall be amended by deleting the reference to "Section 2.9.6.8" and replacing it with the reference to "Section 2.9.8".

64. Section 2.30.22.1 shall be amended by adding the word "also" between the words "shall" and "demonstrate" in the second sentence.

65. Section 3.4.3.3 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 one percent (1%), whether a negative or positive change in scores, the base capitation rates as subsequently adjusted will be proportionally adjusted, unless otherwise specified in the subsections below.

66. Section 3.4.3.7 shall be deleted and replaced in its entirety.

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. For CHOICES Groups 1 and 2 members only, the long-term care component of the base capitation rate will be adjusted according to the relative mix of persons receiving LTC in each service delivery setting (NF versus HCBS) in accordance with the following:

3.4.3.7.1 Member Movement during Implementation and/or annual Open Enrollment Periods

3.4.3.7.1.1 TENNCARE will track CHOICES member change requests that occur from March 1st, 2010 through the completion of the 2010 open enrollment period for enrollees who were enrolled in CHOICES on March 1, 2010.

3.4.3.7.1.1.1 CHOICES members that change MCOs during the open enrollment period will be designated as either a NF enrollee (Group 1) or an HCBS enrollee (Group 2) based upon the determination made in the outbound 834 enrollment file on the date of their official transfer.

3.4.3.7.1.1.2 The net transfer of CHOICES Group 1 and Group 2 members from March 1, 2010 through May 31, 2010 will be compared to the mix of NF/HCBS enrollees in the data book assumptions. If the mix of net transfers exceeds one half (½) of one (1) percent different between the MCOs, rates will be adjusted accordingly.

3.4.3.7.1.2 A similar process will occur in May 2011, after the completion of the open enrollment period for 2011 and following each Open Enrollment Period. This process will compare the effect of net transfers for CHOICES Group 1 and 2 members only as compared to the mix before the 2011(or applicable) annual 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 Group 1 and 2 member enrollment mix due to enrollees changing from one MCO to another and does not address changes in enrollment mix due to other factors.

Amendment 12 (cont.)

67. The PROGRAM ISSUES Column in Items A.16 and A.29 of the Liquidated Damages Chart in Section 4.20.2.2.7 shall be amended by adding the phrase "or 3" after the phrase "Group 2".

LEVEL	PROGRAM ISSUES	DAMAGE
A.16	Failure to comply with the timeframes for developing and approving a plan of care for transitioning CHOICES members in Group 2 or 3, authorizing and initiating nursing facility services for transitioning CHOICES members in Group 1, or initiating long-term care services for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6)	$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS) $10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS) $15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS) $20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS) $25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS) These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement
A.29	Failure to initiate CHOICES HCBS or for children under age 21, EPSDT benefits provided as an alternative to nursing facility care in accordance with the member's plan of care and to ensure that such HCBS or EPSDT benefits are in place immediately upon transition from a nursing facility to the community for any person transitioning from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2 or 3), including persons enrolled in MFP (see Sections 2.9.5.4.1.5 and 2.9.6.8.16)	$500 per day for each day that HCBS are not in place following transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) in addition to the cost of services not provided These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

68. Section 4 shall be amended by adding a new Section 4.40 as follows and renumbering the existing Sections accordingly, including any references thereto.

4.40 SOCIAL SECURITY ADMINISTRATION (SSA) REQUIRED PROVISIONS FOR DATA SECURITY

The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 *(5* U.S.C. §552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.

4.40.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Agreement for any purpose other than that set forth in this Agreement for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

4.40.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Agreement.

4.40.3 Upon request, the CONTRACTOR shall provide a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE.

4.40.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Agreement. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.

4.40.5 The CONTRACTOR shall ensure that its employees:

4.40.5.1 Properly safeguard PHI/PII furnished by TENNCARE under this Agreement from loss, theft or inadvertent disclosure;

4.40.5.2 Understand that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;

4.40.5.3 Ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;

4.40.5.4 Send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and

4.40.5.5 Limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

CONTRACTOR employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Agreement may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

4.40.6 Loss or Suspected Loss of Data – If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact TENNCARE **within one (1) hour** to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.

4.40.6.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.

4.40.7 TENNCARE may immediately and unilaterally suspend the data flow under this Agreement, or terminate this Agreement, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Agreement.

4.40.8 Legal Authority

4.40.8.1 Federal laws and regulations giving SSA the authority to disclose data to TENNCARE and TENNCARE's authority to collect, maintain, use and share data with CONTRACTOR is protected under federal law for specified purposes:

4.40.8.1.1 Sections 1137, 453, and 1106(b) of the Social Security Act (the Act) (42 U.S.C. §§ 1320b-7, 653, and 1306(b)) (income and eligibility verification data);

4.40.8.1.2 26 U.S.C. § 6103(l)(7) and (8) (tax return. data);

4.40.8.1.3 Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. § 401(x)(3)(B)(iv))(prisoner data);

4.40.8.1.4 Section 205(r)(3) of the Act (42, U.S.C. § 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);

4.40.8.1.5 Sections 402, 412, 421, and 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193) (8 U.S.C. §§ 1612, 1622, 1631, and 1645) (August 22, 1996 (quarters of coverage data);

4.40.8.1.6 Children's Health Insurance Program Reauthorization Act of 2009, (Pub. L. 111-3) (February 4, 2009) (citizenship data); and

4.40.8.1.7 Routine use exception to the Privacy Act, 5 U.S.C. § 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).

4.40.8.2 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. § 3541 *et seq.),* and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data.

4.40.9 Definitions

4.40.9.1 "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to TENNCARE to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Agreement between SSA and F&A; IEA between SSA and TENNCARE).

4.40.9.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 CFR §160.103; OMB Circular M-06-19 located at http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

4.40.9.3 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

4.40.9.4 "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

69. Attachment VI shall be amended by adding "TBI MFCU" in the "TO:" section along with "Office of Program Integrity".

70. Exhibit C of Attachment IX shall be deleted in its entirety and replaced by "LEFT BLANK INTENTIONALLY".

ATTACHMENT IX, EXHIBIT C
LEFT BLANK INTENTIONALLY

Amendment 12 (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, 2012.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark H. Emkes/CD
Mark Emkes
Commissioner

DATE: 6/18/2012

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY:
Scott A. Bowers
Chief Executive Officer, TennCare

DATE: 6/15/12

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
Brian Kelsey — Ken Yager
Eric Stewart
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Curtis Johnson, Vice-Chairman
Representatives
Tommie Brown — David Shepard
Jim Coley — Tony Shipley
Charles Curtiss — Curry Todd
Johnny Shaw — Mark White
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

TO: The Honorable Mark Emkes, Commissioner
Department of Finance and Administration

FROM: Senator Bill Ketron, Chairman BK
Representative Curtis Johnson, Vice-Chairman CJ

DATE: February 2, 2012

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 1/30/12)

RFS# 318.66-00051 (Edison # 29634)
Department: Finance & Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment adds language regarding risk capitation rates and payments for members who are determined to receive retro eligibility.
Current maximum liability: $5,324,361,376
Proposed maximum liability: $5,324,361,376

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

cc: The Honorable Darin Gordon, Deputy Commissioner
Ms. Jessica Robertson, Chief Procurement Officer
Mr. Robert Barlow, Director, Office of Contracts Review

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

January 13, 2012

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Bureau of TennCare Managed Care Organization Contract Amendments
SXC Health Solutions, Inc., #3
Public Consulting Group, Inc. #1
Health Management Associates, Inc. #1

Mr. Lucian Geise:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments to these competitively procured contracts for the provision of medical and behavioral services for TennCare enrollees. These amendments are necessary to add language consistent with the proposed budget presented to the Governor by TennCare. The language clarifies that each MCO will receive full risk capitation payments for up to 12 months prior to the member's enrollment in the plan for members who are determined to receive retro eligibility. Beyond the 12 month period, rather than the full capitation rate, the MCO will invoice TennCare for actual expenditures. By making this language change to all of the MCO contracts, TennCare is projected to realize a moderate reduction in payments.

AMERIGROUP Tennessee, Inc.	FA-07-16936-11
UnitedHealthCare Plan of River Valley, Inc.	FA-07-16937-11
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-08
Volunteer State Health Plan (West Region)	FA-08-24978-08
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-08
Volunteer State Health Plan (East Region)	FA-08-24983-08

Secondly, TennCare is submitting for consideration amendment #3 to SXC Health Solutions, Inc, the contract for Pharmacy Management and Preferred drugs list server for the Bureau of TennCare. This competitively procured contract amendment extends the term of the contract for the 5th and final year and provides funding to support this extension. The Bureau is developing language to release an RFP to competitively identify a contractor to assume the Pharmacy management contract when this current term ends.

Finally, we are submitting for consideration amendments to the existing contracts with Public Consulting Group, Inc. and Health Management Associates, Inc., for the purpose of providing additional funding for policy and operational consulting services regarding health insurance exchanges and for making evidence-based recommendations to the State. Since the execution of these competitively procured contracts, one of the three competitively procured Contractors (Dell) that received a contract award under the initial Request for Proposal has indicated that it is unable to perform functions specified in the scope of work due to loss of key subject matter consulting staff. This inability to perform work for the State results in the need for redistribution of unused funds to the PCG and HMA contracts. Additionally, the State has received additional planning funds to analyze evolving federal guidance regarding the exchange marketplaces. Because of the continuing policy changes at the federal level and the magnitude of the market impacts in Tennessee, the State sought additional planning funds which were awarded on November 29, 2011. We now need the corresponding technical assistance that these two competitively procured contracts can provide to analyze the emerging issues in the market and revise our recommendations if and as appropriate. The State indicated in both the RFP and resulting contract that contract funding would be increased as needed and as availability of additional federal funding dictated.

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

Sincerely,

Casey Dungan
Chief Financial Officer

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: (*if applicable*)	29634	Edison RFS Number: (*if applicable*)	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: (*if applicable*)	11
Proposed Amendment Effective Date: (*if applicable*)	March 15, 2012
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	January 13, 2012
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$5,324,361,376.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$376,192,454.05

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:	$1,726,441,032.00	Federal:	$3,597,920,344.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.
Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.

Supplemental Documentation Required for Fiscal Review Committee

Amendment #10 – January 1, 2012	Program Integrity Updates, HIPAA/HITECH clarifications; CHOICES updates; Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; Increase funding to support the services for this contract for FY '12 and FY '13 based on actual expenditures
Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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).

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.

Supplemental Documentation Required for Fiscal Review Committee

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.

MCO 031 AMERICHOICE MIDDLE

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

UnitedHealthCare Plan (Americhoice) - Middle
FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

UnitedHealthCare Plan (Americhoice) - Middle
FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL **$1,051,885,932.05**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2012

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00357932	0000021799	80,164,116.78	8/1/2011
31865	00357935	0000021799	1,749.12	8/1/2011
31865	00373132	0000021799	66,259,994.41	9/2/2011
31865	00373135	0000021799	4,290.68	9/2/2011
			146,430,150.99	
31865	00390204	0000021799	68,500,422.24	10/7/2011
31865	00390207	0000021799	1,970.72	10/7/2011
31865	00396234	0000021799	16,338,030.88	10/17/2011
31865	00396235	0000021799	189,155.42	10/17/2011
31865	00404008	0000021799	77,882,668.64	11/4/2011
31865	00404011	0000021799	1,159.98	11/4/2011
31865	00417176	0000021799	66,848,857.76	12/5/2011
31865	00417179	0000021799	37.42	12/5/2011
			229,762,303.06	

FY 2012 TOTAL $ 376,192,454.05

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 – 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

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

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

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

ATTACHMENT X

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

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

125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".

126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".

127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

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

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

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED
COMMISSIONER OF FINANCE & ADMINISTRATION

Request Tracking #	**31866-00051**
Procuring Agency	**Department of Finance and Administration Bureau of TennCare**
Contractor	**UnitedHealthCare Plan of the River Valley, Inc.**
Contract #	**FA-07-16937-00**
Proposed Amendment #	**11**
Edison ID #	**29634**

Contract Begin Date	**August 15, 2006**
Current Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Proposed Contract End Date *– with ALL options to extend exercised*	**December 31, 2014**
Current Maximum Contract Cost *– with ALL options to extend exercised*	**$ 5,324,361,376.00**
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	**$ 5,324,361,376.00**
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	**X Not Applicable** ☐ **Attached**
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	**X Not Applicable** ☐ **Attached**
Human Resources Support *– state employee training service*	**X Not Applicable** ☐ **Attached**

Explanation Need for the Proposed Amendment

This contract is a competitively procured contract providing medical and behavioral services to TennCare enrollees. This proposed amendment is necessary to add language consistent with the proposed budget presentation presented to the Governor by TennCare. The language clarifies that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility.

Request Tracking #	31866-00051

Beyond the 12 month period, rather than the full capitation rate, the MCO will invoice TennCare for actual expenditures. By making this language change to all of the MCO contracts, TennCare will realize a moderate statewide reduction in payments.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to add language consistent with the proposed budget presentation presented to the Governor by TennCare. The language clarifies that Managed Care Organizations (MCO) will receive full risk capitation payments for up to 12 months prior the member's enrollment in the plan for members who are determined to get retro eligibility. Beyond the 12 month period, rather than the full capitation rate, the MCO will invoice TennCare for actual expenditures. By making this language change to all of the MCO contracts, TennCare will realize a moderate statewide reduction in payments. The Bureau of TennCare would greatly appreciate the approval of this amendment.

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark C. Emkes 1/11/2012

CONTRACT SUMMARY SHEET

021406

RFS #	Edison #	Contract #
31866-00051	29634	FA-07-16937-11

State Agency
Department of Finance and Administration

State Agency Division
Bureau of TennCare

Contractor Name
UnitedHealthCare Plan of the River Valley, Inc.

Contractor ID # (FEIN or SSN)
[ ] C- or [X] V- Edison Vendor #0000021792

Service Description
Provision of Physical and Behavioral Health Services to TennCare Enrollees in the Middle Tennessee Region

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2010	$ 195,060,989.00	$ 587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
TOTAL:	$ 1,726,441,032.00	$ 3,597,920,344.00	$ -	$ -	$ 5,324,361,376.00

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$ 174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
2013	$ 989,205,835.00	
TOTAL:	$ 5,324,361,376.00	$0.00
End Date	December 31, 2014	December 31, 2014

State Agency Fiscal Contact & Telephone #
Casey Dungan 507-6482

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 intended to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership (complete only for base contracts with contract # prefix FA or GR)
[ ] African American [ ] Person w/ Disability [ ] Hispanic [ ] Small Business [x] NOT disadvantaged
[ ] Asian [ ] Female [ ] Native American [ ] OTHER minority/disadvantaged—

Contractor Selection Method (complete for ALL base contracts— N/A to amendments or delegated authorities)
[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government (eg ID GC GU) [ ] Other

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

FA0716937-11

AMENDMENT NUMBER 11
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. Section 3.1.2 shall be amended by adding the phrase "any payments for claims incurred during a period of retroactive eligibility greater than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR," in the first sentence as follows:

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, any payments for claims incurred during a period of retroactive eligibility greater than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR, any incentive payments (if applicable), any payments related to FQHC/RHC costs and any payments that offset the CONTRACTOR's cost for the development and implementation of an electronic visit verification system (EVV) (see Section 3.15) are payment in full for all services provided pursuant to this Agreement. TENNCARE shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at TCA 56-32-101 *et seq.* or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at TCA 56-51-101 *et seq.* or any subsequent amendments thereto. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

2. Section 3.7.1.2 shall be amended by adding a new Section 3.7.1.2.2 and renumbering the remaining Section accordingly, including any references thereto.

3.7.1.2.2 The CONTRACTOR will not receive a capitation payment for periods of retroactive eligibility greater than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR. The CONTRACTOR agrees to process claims and reimburse providers for services incurred during a period of retroactive eligibility more than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR; however, the CONTRACTOR will not be at risk for these services. Actual expenditures for covered services are subject to TCA 56-32-124. The CONTRACTOR shall reimburse providers in accordance with this Agreement and shall submit to TENNCARE on a monthly basis a claims invoice file for the provision of covered services incurred during an enrollee's period of retroactive eligibility greater than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-124 within ten (10) business days of receipt of notice; however, TENNCARE reserves the right to further review such claims and to recover any overpayments subsequently identified. The CONTRACTOR shall release payments to providers within two (2) business days of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-124. Based on the provisions herein, TENNCARE shall not make any further retroactive adjustments, other than those described herein, beyond those already received as of October 2011.

3. Section 3.7.1.4 and 3.7.1.4.1 shall be deleted and replaced by new Sections 3.7.1.4 through 3.7.1.4.3 as follows:

3.7.1.4 Should TENNCARE determine after the capitation payment is made that an enrollee's capitation rate category had changed or the enrollee was deceased, TENNCARE shall retroactively adjust the payment to the CONTRACTOR as follows:

3.7.1.4.1 If an enrollee is deceased, TENNCARE shall recoup any and all capitation payments made after the enrollee's date of death, including any pro-rated share of a capitation payment intended to cover dates of service after the enrollee's date of death.

3.7.1.4.2 If an enrollee's capitation rate category has changed, TENNCARE shall retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period for which payment has been made, up to a maximum of twelve (12) months. For changes in an enrollee's eligibility category covering a retroactive period greater than twelve (12) months that affect an enrollee's capitation rate category, the capitation payment made to the CONTRACTOR for periods greater than twelve (12) months shall not be adjusted, and the CONTRACTOR shall consider the capitation payment already received as payment in full. Based on the provisions herein, TENNCARE shall not make any further retroactive adjustments, other than those described herein, beyond those already received as of October 2011.

3.7.1.4.3 TENNCARE and the CONTRACTOR agree that the twelve (12) month limitation described in Sections 3.7.1.4 is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the CONTRACTOR's MCO.

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 March 15, 2012.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A. Emkes/LD
Mark Emkes
Commissioner

DATE: 2/3/2012

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY:
Scott A. Bowers
Chief Executive Officer, TennCare

DATE: 1/31/12

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
Brian Kelsey, Ken Yager
Eric Stewart
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Curtis Johnson, Vice-Chairman
Representatives
Tommie Brown, David Shepard
Jim Coley, Tony Shipley
Charles Curtiss, Curry Todd
Johnny Shaw, Mark White
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

TO: The Honorable Mark Emkes, Commissioner
Department of Finance and Administration

FROM: Senator Bill Ketron, Chairman BK
Representative Curtis Johnson, Vice-Chairman CJ

DATE: November 16, 2011

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 11/15/11)

RFS# 318.66-051 (Edison # N/A)
Department: Finance & Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment implements Program Integrity and CHOICES updates, HIPAA/HITECH clarifications, updates liquidated damages, and increases maximum liability by $989,205,835.
Current maximum liability: $4,335,155,541
Proposed maximum liability: $5,324,361,376

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

cc: The Honorable Darin Gordon, Deputy Commissioner
Ms. Jessica Robertson, Chief Procurement Officer
Mr. Robert Barlow, Director, Office of Contracts Review

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	N/A	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	10
Proposed Amendment Effective Date: *(if applicable)*	January 1, 2012
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	October 31, 2011
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$4,335,155,541.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY 2012
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$146,430,150.99

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:	$1,391,950,970	Federal:	$2,943,204,571.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.
Amendment #9 – October 1, 2011	Inclusion of Money Follows the Person Rebalancing Demonstration Grant. No funding.

Supplemental Documentation Required for Fiscal Review Committee

Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to the 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:

Supplemental Documentation Required for Fiscal Review Committee

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.

MCO 031 AMERICHOICE MIDDLE

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

UnitedHealthCare Plan (Americhoice) - Middle
FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL **$1,051,885,932.05**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2012

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00357932	0000021799	80,164,116.78	8/1/2011
31865	00357935	0000021799	1,749.12	8/1/2011
31865	00373132	0000021799	66,259,994.41	9/2/2011
31865	00373135	0000021799	4,290.68	9/2/2011
			146,430,150.99	

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 – 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

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

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

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

ATTACHMENT X

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

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

125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".

126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".

127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

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

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

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED
COMMISSIONER OF FINANCE & ADMINISTRATION

Request Tracking #	31866-00051
Procuring Agency	Department of Finance and Administration Bureau of TennCare
Contractor	UnitedHealthCare Plan of the River Valley, Inc.
Contract #	FA-07-16937-00
Proposed Amendment #	10
Edison ID #	NA

Contract Begin Date	August 15, 2006
Current Contract End Date – *with ALL options to extend exercised*	December 31, 2014
Proposed Contract End Date – *with ALL options to extend exercised*	December 31, 2014
Current Maximum Contract Cost – *with ALL options to extend exercised*	$4,335,155,541.00
Proposed Maximum Contract Cost – *with ALL options to extend exercised*	$ 5,324,361,376.00
Office for Information Resources Endorsement – *information technology service (N/A to THDA)*	X Not Applicable ☐ Attached
eHealth Initiative Support – *health-related professional, pharmaceutical, laboratory, or imaging service*	X Not Applicable ☐ Attached
Human Resources Support – *state employee training service*	X Not Applicable ☐ Attached

Explanation Need for the Proposed Amendment

This contract is a competitively procured contract providing medical and behavioral services to TennCare enrollees. This amendment is necessary to implement (1) Program Integrity Updates including the clarification of CMS expectations based on recent CMS audit; (2) HIPAA/HITECH clarifications including updating language to reflect current requirements associated with reporting timelines and LDs for non-compliance; (3) CHOICES updates relating to the introduction of

Request Tracking #	31866-00051

suggested Care Manager Ratios; (4) Quality Clarifications regarding the use of Hybrid methodology for HEDIS and Outreach Activity planning and reporting; (5) Cap Rate Updates, and (6) Increases funding to support the behavioral and medical services for this contract for FY '13.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and deliver products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals), 4,800 hospitals and their pharmaceutical management programs which provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region. This amendment represents the State's compliance with federal requirements to strengthen specific language which will provide optimum services to enrollees covered by this plan.

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to implement necessary program language updates as required by the Center for Medicare and Medicaid Services. These program changes strengthen the contract by adding requirements and timelines necessary to benefit the enrollees of the TennCare Program and to add liquidated damages should the managed care company not comply with added requirements. The Bureau of TennCare would greatly appreciate the approval of this amendment.

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark C. Emko 10/28/11

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
31866-00051 EDISON ID 29634	FA-07-16937-10
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,135.00	$ 655,180,700.00			$ 989,205,835.00
2013	$ 334,490,061.00	$ 654,715,774.00			$ 989,205,835.00
TOTAL:	$ 1,726,441,032.00	$ 3,597,920,344.00	$ -	$ -	**$ 5,324,361,376.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	$ -
2013		$ 989,205,835.00
TOTAL:	**$ 4,335,155,541.00**	**$ 989,205,835.00**
End Date	December 31, 2014	December 31, 2014

State Agency Fiscal Contact & Telephone #

Casey Dungan 507-6482

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 only for base contracts with contract # prefix: FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg,ID,GG,GU) [ ] Other

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

AMENDMENT NUMBER 10
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. Section 1 shall be amended by adding the following definitions:

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

Breach (with respect to Protected Health Information (PHI)) - The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the protected health information.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (see 42 CFR 455.2).

Repayment – The process by which an MCO, the State of Tennessee or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

2. Section 2.7.4.1 shall be deleted and replaced as follows:

2.7.4.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities shall include TENNderCare outreach activities (See Section 2.7.6.2) and may also include the following:

3. Section 2.7.4.2 shall be deleted and replaced by Sections 2.7.4.2 through 2.7.4.2.3 as follows:

2.7.4.2 The CONTRACTOR shall submit an Annual Community Outreach Plan no later than November 30 of each year for review and approval by TENNCARE.

2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; community/health education events unrelated to TENNderCare; rationale for participating in these events; and a process for evaluating the benefits of the events.

2.7.4.2.2 The CONTRACTOR's TennCare approved Annual Community Outreach Plan shall be implemented on January 1 of each year.

2.7.4.2.3 Community/health education events, both related and unrelated to TENNderCare, shall be included in the quarterly TENNderCare Report (See Section 2.30.4.4) in a format specified by TENNCARE.

4. Section 2.7.6.2.10 shall be amended by adding the reference "(See Section 2.7.4.2)" to the end of the first sentence.

5. Section 2.9.5.4.1 through 2.9.5.4.1.4 shall be deleted and replaced as follows:

2.9.5.4.1 In addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home will be provided coordination of care by the CHOICES Care Coordinator and MCO Case Management staff:

2.9.5.4.1.1 The member will be informed by the CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;

2.9.5.4.1.2 Within three (3) business days of a request to transition by or on behalf of a Group 1 member under age 21, the member will be referred by the CHOICES Care Coordinator to MCO Case Management for service identification and implementation in the home setting;

2.9.5.4.1.3 The MCO Case Manager will be responsible for developing a service plan for the home setting;

2.9.5.4.1.4 The CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the MCO Case Management staff, the member and/or his parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until the transition plan is complete; and

6. Section 2.9.6.1.6.1 shall be amended by adding a ")" after the word "computation".

7. Section 2.9.6.2.5.1 shall be deleted and replaced as follows:

2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services that are covered in CHOICES, the CONTRACTOR shall, immediately upon notice of the member's enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. In the case of those members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility, community-based residential alternative services shall

be authorized immediately upon notice of the member's categorical and financial eligibility for TennCare CHOICES as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider.

8. Section 2.9.6.3.7 shall be deleted and replaced as follows:

2.9.6.3.7 If the member does not meet the telephone screening criteria, the CONTRACTOR shall within five (5) business days of the screening notify the member verbally and in writing in the format prescribed by TENNCARE: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall process the request as a new referral and shall conduct a face-to-face intake visit, including level of care assessment and needs assessment, within ten (10) business days of receipt of the member's written request, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

9. Section 2.9.6.6.1.1 shall be amended by adding the word "CHOICES" in front of the word "file".

10. Section 2.9.6.6.2.7 shall be deleted and replaced as follows:

2.9.6.6.2.7 The member's care coordinator/care coordination team shall provide a copy of the member's completed plan of care, including any updates, to the member, the member's representative, as applicable, and the member's community residential alternative provider, as applicable. The member's care coordinator/care coordination team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such providers who do not receive a copy of the plan of care are informed in writing prior to the scheduled implementation of services of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to the tasks and functions to be performed.

11. Section 2.9.6.6.2.8 shall be amended by adding a new Section 2.9.6.6.2.8.1 which shall read as follows:

2.9.6.6.2.8.1 Within three (3) business days of updating the member's plan of care, the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the supports broker, as applicable, and to other providers authorized to deliver care to the member. Relevant information shall include any information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to any changes in the tasks and functions to be performed.

12. Section 2.9.6.8.25.3 and Section 2.9.6.8.25.4 shall be deleted and replaced by new Sections 2.9.6.8.25.3, 2.9.6.8.25.4 and 2.9.6.8.25.4.1 as follows:

2.9.6.8.25.3 The CONTRACTOR shall conduct a census at least semi-annually at no less than one hundred twenty (120)-day intervals or as frequently as deemed necessary by TENNCARE to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.

2.9.6.8.25.4 The CONTRACTOR shall authorize and/or reimburse short-term NF stays for Group 2 members only when the member's stay in the facility is expected to be less than ninety (90) days and the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 members and shall ensure that the member is transitioned from Group 2 to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 members.

2.9.6.8.25.4.1 Upon request, the CONTRACTOR shall provide to TENNCARE a member-by-member status for each Group 2 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, and the anticipated date of discharge back to the community.

13. Section 2.9.6.9.1.1.4 shall be amended by deleting the word "and" at the end of the text and Section 2.9.6.9.1.1.5 shall be deleted and replaced as follows:

2.9.6.9.1.1.5 In the manner prescribed by TENNCARE and in accordance with this Agreement and TENNCARE policies and protocols pertaining thereto: 1) facilitate transfers between nursing facilities which, at a minimum, includes notification to the receiving facility of the member's level of care, and notification to DHS; and 2) facilitate transitions to CHOICES Group 2 which shall include (but is not limited to) timely notification to TENNCARE; and

14. Section 2.9.6.9.2.1.2 shall be deleted and replaced as follows:

2.9.6.9.2.1.2 During the development of the member's plan of care and as part of the annual updates, the care coordinator shall discuss with the member his/her interest in consumer direction when eligible CHOICES HCBS are included in the plan of care;

15. Section 2.9.6.9.2.1.15 shall be amended by deleting the word "and" at the end of the text, Section 2.9.6.9.2.1.17 shall be amended by deleting the "." and adding "; and", and Section 2.9.6.9.2.1 shall be amended by adding a new Section 2.9.6.9.2.1.18 as follows:

2.9.6.9.2.1.18 In the manner prescribed by TENNCARE, and in accordance with this Agreement and TENNCARE policies and protocols pertaining thereto, facilitate transition to CHOICES Group 1, which shall include (but is not limited to) timely notification to TENNCARE.

16. Section 2.9.6.10.3 shall be deleted and replaced by new Sections 2.9.6.10.3 through 2.9.6.3.10.3.3 as follows:

2.9.6.10.3 If a member elects not to receive eligible CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS:

2.9.6.10.3.1 The CONTRACTOR shall document this decision, including date and member/member's representative's signature, in the manner specified by TENNCARE (see Section 2.9.7.4.3.2 of this Agreement).

2.9.6.10.3.2 The member's care coordinator shall visit the member face to face at least monthly to ensure that the member's needs are met, and shall continue to offer eligible CHOICES HCBS through contract providers (See Section 2.9.7.4.3.3).

2.9.6.10.3.3 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2.

17. Section 2.9.6.10 shall be amended by adding a new Section 2.9.6.10.11 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.10.11 Within three (3) business days of updating the member's plan of care, the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the supports broker (see Section 2.9.6.6.2.8.1. of this Agreement).

18. Section 2.9.6.11.3 through 2.9.6.11.5 shall be deleted and replaced as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.9.6.11.3 The CONTRACTOR shall ensure that an adequate number of care coordinators are available and that sufficient staffing ratios are maintained to address the needs of CHOICES members and meet all the requirements described in this Agreement.

2.9.6.11.4 The recommended average weighted care coordinator-to-CHOICES member staffing ratio is no more than 1:125. Such average shall be derived by dividing the total number of full-time equivalent care coordinators by the total weighted value of CHOICES members as delineated below.

2.9.6.11.5 The recommended maximum caseload for any individual care coordinator is a weighted value of no more than one hundred seventy-five (175) CHOICES members.

2.9.6.11.6 The contractor shall use the following methodology to calculate weighted care coordinator-to-CHOICES member staffing ratios and care coordinator caseloads:

2.9.6.11.6.1 Each CHOICES Group 1 member shall be factored into the weighted care coordinator-to-CHOICES member staffing ratio and weighted caseload calculations utilizing an acuity level of one (1), EXCEPT that:

2.9.6.11.6.1.1 Upon completion of a Transition Assessment which indicates that a Group 1 member is a candidate for transition to the community, such member shall be factored into the weighted caseload and staffing ratio calculations using an acuity level of two and one-half (2.5) until such time as the member is transitioned to CHOICES Group 2 or the member is no longer a candidate for transition;

2.9.6.11.6.1.2 CHOICES Group 1 members under twenty-one (21) years of age shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5).

2.9.6.11.6.2 Each CHOICES Group 2 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5);

2.9.6.11.6.3 Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125:

Weighted Caseload Mix for a **1:125** Ratio		
CH1 (Acuity 1.0)	CH 2 (Acuity 2.5)	Total CHOICES Members on Caseload
125	0	125
100	10	110
75	20	95
50	30	80
25	40	65
0	50	50

2.9.6.11.6.4 Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175:

Weighted Caseload Mix for a **1:175** Ratio		
CH1 (Acuity 1.0)	CH 2 (Acuity 2.5)	Total CHOICES Members on Caseload
175	0	175
150	10	160
125	20	145
100	30	130
75	40	115
50	50	100
25	60	85
0	70	70

2.9.6.11.7 The CONTRACTOR shall proactively plan for staff turnover and shall monitor caseload assignments and weighted care coordinator-to-CHOICES member staffing ratios and adjust hiring practices and care coordinator assignments as necessary to meet the requirements of this Agreement and to address members' needs.

2.9.6.11.8 Upon request, the CONTRACTOR shall provide to TENNCARE documentation of such monitoring, including an itemized list by care coordinator of the total number of members assigned, and the number of Group 1 members (including members in transition and children under age 21) and Group 2 members that comprise each care coordinator's caseload.

2.9.6.11.9 In the event that the CONTRACTOR is determined to be deficient with any requirement pertaining to care coordination as set forth in this agreement, the amount of financial sanctions assessed shall take into account whether or not the CONTRACTOR has complied with the recommended average weighted care coordinator to CHOICES member staffing ratio and the maximum weighted care coordinator caseload amounts set forth in Sections 2.9.6.11.4 and 2.9.6.11.5, based on the most recent monthly CHOICES Caseload and Staffing Ratio Report (see Section 2.30.6.8). All applicable sanctions set forth in Sections 4.20.2.2.6., 4.20.2.2.7.A.16, 4.20.2.2.7.A.18, 4.20.2.2.7.A.19, 4.20.2.2.7.A.20, 4.20.2.2.7.A.21, 4.20.2.2.7.A.22, 4.20.2.2.7.A.23, 4.20.2.2.7.A.28, 4.20.2.2.7.A.29, 4.20.2.2.7.A.30, 4.20.2.2.7.A.31, 4.20.2.2.7.B.21, and 4.20.2.2.7.C.7 of this agreement shall be multiplied by two (2) when the CONTRACTOR has not complied with these recommendations.

2.9.6.11.10 TennCare will reevaluate Care Coordinator-to-CHOICES member staffing ratio recommendations and requirements on at least an annual basis and may make adjustments based on the needs of CHOICES members, CHOICES program requirements and MCO performance.

2.9.6.11.11 TENNCARE may request changes in the CONTRACTOR's Care Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient care coordination staff to properly and timely perform its obligations under this Agreement.

19. The renumbered Section 2.9.6.11.18 shall be amended by deleting the words "at least annually".

20. Section 2.9.6.11 shall be amended by adding a new Section 2.9.6.11.19 as follows and renumbering the remaining Section including any references thereto.

2.9.6.11.19 The CONTRACTOR shall establish an ongoing training program for care coordinators. Topics to be covered shall be determined by the CONTRACTOR based on its monitoring of care coordination (see Section 2.9.6.12) and the CHOICES program, and feedback from TENNCARE.

21. Section 2.9.6.12.7 shall be amended by adding the words "and document" as follows:

2.9.6.12.7 The CONTRACTOR shall develop and maintain an electronic case management system that includes the functionality to ensure and document compliance with all requirements specified in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols, including but not limited to the following:

22. Section 2.12.4 shall be deleted and replaced as follows:

2.12.4 LEFT BLANK INTENTIONALLY

23. Section 2.12.9 shall be deleted and replaced as follows and all references to Section 2.12.9 shall be updated accordingly.

2.12.9 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, except as otherwise provided in Section 2.12.13, at a minimum, meet the following requirements:

2.12.9.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;

2.12.9.2 Specify the effective dates of the provider agreement;

2.12.9.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

2.12.9.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior written approval of the CONTRACTOR;

2.12.9.5 Identify the population covered by the provider agreement;

2.12.9.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

2.12.9.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

2.12.9.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;

2.12.9.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;

2.12.9.10 Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section 2.11 of the CONTRACTOR's Agreement with TENNCARE;

2.12.9.11 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR and include the definition of unreasonable delay as described in Section 2.7.5.2.3 of this Agreement;

2.12.9.12 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

2.12.9.13 Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements;

2.12.9.14 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees and providers shall give TENNCARE or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR,

TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;

2.12.9.16 Include medical records requirements found in Section 2.24.6 of this Agreement;

2.12.9.17 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;

2.12.9.18 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;

2.12.9.19 Provide for monitoring, whether announced or unannounced, of services rendered to members;

2.12.9.20 Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;

2.12.9.21 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;

2.12.9.22 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

2.12.9.23 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

2.12.9.24 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;

2.12.9.25 Provide the name and address of the official payee to whom payment shall be made;

2.12.9.26 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR. However, the agreement shall not include rate methodology that provides for an automatic increase in rates;

2.12.9.27 Specify that the CONTRACTOR shall only pay providers for services (1) provided in accordance with the requirements of this Agreement, the CONTRACTOR's policies and procedures implementing this Agreement, and state and federal law and (2) provided to TennCare enrollees who are enrolled with the CONTRACTOR; and specify that the provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service;

2.12.9.28 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;

2.12.9.29 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section 2.22.4 of this Agreement;

2.12.9.30 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;

2.12.9.31 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

2.12.9.32 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.7 of this Agreement;

2.12.9.33 Specify the provider's responsibilities regarding third party liability (TPL) , including the provider's obligation to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and, except as otherwise provided in the CONTRACTOR's Agreement with TENNCARE, to seek such third party liability payment before submitting claims to the CONTRACTOR;

2.12.9.34 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

2.12.9.34.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and

2.12.9.34.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;

2.12.9.35 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;

2.12.9.36 Require that the provider comply with the Affordable Care Act and TennCare policy and procedures, including but not limited to, reporting overpayments and, when it is applicable, return overpayments to the CONTRACTOR within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law;

2.12.9.37 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 TennCare policies and procedures. The timeframes for this requirement shall include, at a minimum, at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request;

2.12.9.38 Any reassignment of payment must be made in accordance with 42 CFR 447.10. All tax-reporting provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (EPLS) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited;

2.12.9.39 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed by the CONTRACTOR that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members;

2.12.9.40 The provider, subcontractor or any other entity agrees to abide by the Medicaid laws, regulations and program instructions that apply to the provider. The provider, subcontractor or any other entity understands that payment of a claim by TennCare or a TennCare Managed Care Contractor and/or Organization is conditioned upon the claim and the underlying

transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the provider's, subcontractor's or any other entity's compliance with all applicable conditions of participation in Medicaid. The provider, subcontractor or any other entity understands and agrees that each claim the provider, subcontractor or any other entity submits to TennCare or a TennCare Managed Care Contractor and/or Organization constitutes a certification that the provider, subcontractor or any other entity has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein;

2.12.9.41 Require the provider to conduct background checks in accordance with state law and TennCare policy;

2.12.9.42 Require the provider to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;

2.12.9.43 Require that, for CHOICES members, the provider facilitate notification of the member's care coordinator by notifying the CONTRACTOR, in accordance with the CONTRACTOR's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;

2.12.9.44 Require hospitals, including psychiatric hospitals, to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion plan (see Section 2.9.6.7), which shall, include, at a minimum, the hospital's obligation to promptly notify the CONTRACTOR upon admission of an eligible member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or CHOICES HCBS upon discharge, and how the hospital will engage the CONTRACTOR in the discharge planning process to ensure that members receive the most appropriate and cost-effective medically necessary services upon discharge;

2.12.9.45 As a condition of reimbursement for global procedures codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;

2.12.9.46 Except as otherwise specified in Sections 2.12.11 or 2.12.12, require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

2.12.9.47 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;

2.12.9.48 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);

2.12.9.49 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any provider agreement in accordance with the terms of the CONTRACTOR's Agreement with TENNCARE (see Section 4.4) and applicable law and regulation;

2.12.9.50 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State;

2.12.9.51 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4.4 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;

2.12.9.52 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);

2.12.9.53 Include a Conflict of Interest clause as stated in Section 4.19 of this Agreement, Gratuities clause as stated in Section 4.23 of this Agreement, and Lobbying clause as stated in Section 4.24 of this Agreement between the CONTRACTOR and TENNCARE;

2.12.9.54 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section 4.31 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;

2.12.9.55 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 4.33 of this Agreement;

2.12.9.56 Require the provider to comply with 42 CFR Part 438, Managed care, including but not limited to 438.6(f)(2)(i), compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the CONTRACTOR and TENNCARE;

2.12.9.57 Specify provider actions to improve patient safety and quality;

2.12.9.58 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:

2.12.9.58.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and

2.12.9.58.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.);

2.12.9.59 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;

2.12.9.60 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;

2.12.9.61 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;

2.12.9.62 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.7.6 of this Agreement. All provider agreements shall contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or include language to require that these sections be furnished to the provider upon request;

2.12.9.63 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term care services covered by TENNCARE;

2.12.9.64 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

2.12.9.65 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

2.12.9.66 The provider shall not use TennCare's name or trademark for any materials intended for dissemination to their patients unless said material has been submitted to TENNCARE by the CONTRACTOR for review and has been approved by TENNCARE in accordance with Section 2.17 of this Agreement. This prohibition shall not include references to whether or not the provider accepts TennCare; and

2.12.9.67 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.

24. Section 2.12.12.9 shall be amended by adding a new Section 2.12.12.9.3 which shall read as follows:

2.12.12.9.3 Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES members that should instead be referred to the person's MCO or AAAD, as applicable;

25. Section 2.12.12.10 shall be amended by deleting the word "and" at the end of the sentence.

26. Section 2.12.12 shall be amended by adding new Sections 2.12.12.12 and 2.12.12.13 as follows:

2.12.12.12 Prohibit CHOICES providers from altering in any manner official CHOICES or MFP brochures or other CHOICES or MFP materials unless the CONTRACTOR has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section 2.17 of this Agreement; and

2.12.12.13 Prohibit CHOICES providers from reproducing for its own use the CHOICES or MFP logos unless the CONTRACTOR has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section 2.17 of this Agreement.

27. Section 2.13.1 shall be amended by deleting and replacing Section 2.13.1.5 and adding new Sections 2.13.1.6, 2.13.1.7 and 2.13.1.8 as follows:

2.13.1.5 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements, as applicable, have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106, Section 2.12.9.37 of this Agreement, and TennCare policies and procedures.

2.13.1.6 The CONTRACTOR, as well as its subcontractors and tax-reporting provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (EPLS) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

2.13.1.7 For any entities to which the CONTRACTOR makes payment via electronic transfers, the CONTRACTOR shall have a signed EFT form that shall have 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section.

2.13.1.8 The CONTRACTOR's failure to implement State Budget Reductions as described by TENNCARE may, at the discretion of TENNCARE, result in the CONTRACTOR forfeiting savings that would have been realized based on the timely implementation, including the forfeiture of recoupment from providers.

28. Section 2.14.1 shall be amended by deleting and replacing Section 2.14.1.1 and adding new Sections 2.14.1.2 through 2.14.1.4. The remaining Sections shall be renumbered accordingly, including any references thereto.

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program which shall be documented in writing. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program.

2.14.1.2 The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.3 The UM program description, associated work plan, and annual evaluation of the UM program shall be submitted to TENNCARE (See Section 2.30.11.1).

2.14.1.4 The UM program, including the UM program description, associated work plan, and annual evaluation shall address Emergency Department (ED) utilization and ED diversion efforts.

29. The renumbered Section 2.14.1.16.1 shall be deleted and replaced as follows:

2.14.1.16.1 Review ED utilization data, at a minimum, every six (6) months to identify members with utilization exceeding the threshold defined by TENNCARE as ten (10) or more visits in the defined six (6) month period. The review due March 31st shall cover ED utilization during the preceding July through December; the review due September 30th shall cover ED utilization during the preceding January through June (See Section 2.30.11.7).

30. Section 2.15.6.1 shall be amended by adding a new Section 2.15.6.1.1 and 2.15.6.1.2 which shall read as follows:

2.15.6.1.1 Beginning with HEDIS 2012, the CONTRACTOR shall utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA.

2.15.6.1.2 The CONTRACTOR shall submit to TENNCARE by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported".

31. Section 2.15.7 shall be deleted and replaced as follows:

2.15.7 **Critical Incident Reporting and Management**

2.15.7.1 CHOICES Critical Incident Reporting and Management

2.15.7.1.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting, including: community-based residential alternatives; adult day care centers; other CHOICES HCBS provider sites; and a member's home, if the incident is related to the provision of covered CHOICES HCBS.

2.15.7.1.2 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.

2.15.7.1.3 Critical incidents shall include but not be limited to the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section 2.15.7.1.1 above):

2.15.7.1.3.1 Unexpected death of a CHOICES member;

2.15.7.1.3.2 Suspected physical or mental abuse of a CHOICES member;

2.15.7.1.3.3 Theft or financial exploitation of a CHOICES member;

2.15.7.1.3.4 Severe injury sustained by a CHOICES member;

2.15.7.1.3.5 Medication error involving a CHOICES member;

2.15.7.1.3.6 Sexual abuse and/or suspected sexual abuse of a CHOICES member; and

2.15.7.1.3.7 Abuse and neglect and/or suspected abuse and neglect of a CHOICES member.

2.15.7.1.4 The CONTRACTOR shall require its staff and contract CHOICES HCBS providers to report, respond to, and document critical incidents as specified by the CONTRACTOR. This shall include, but not be limited to the following:

2.15.7.1.4.1 Requiring that the CONTRACTOR's staff and contract CHOICES HCBS providers report critical incidents to the CONTRACTOR in accordance with applicable requirements. The CONTRACTOR shall develop and implement a critical incident reporting process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the CONTRACTOR shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

2.15.7.1.4.2 Requiring that suspected abuse, neglect, and exploitation of members who are adults is immediately reported in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of members who are children is immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.

2.15.7.1.4.3 Requiring that its staff and contract CHOICES HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

2.15.7.1.4.4 Requiring that contract CHOICES HCBS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the CONTRACTOR. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) days after the date of the incident. The CONTRACTOR shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

2.15.7.1.4.5 Requiring that its staff and contract CHOICES HCBS providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, APS, CPS, and law enforcement).

2.15.7.1.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in a accordance with Section 2.15.7.1.4.1, investigating critical incidents, submitting a report on investigations to the CONTRACTOR and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section 2.9.7.8.6); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.7.1.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.15.7.1.4.7 Reviewing the FEA's reports and investigations regarding critical incidents and follow-up with the FEA as necessary regarding corrective actions determined by the member and/or his/her representative to help ensure the member's health and safety.

2.15.7.1.4.8 Providing appropriate training and taking corrective action as needed to ensure its staff, contract CHOICES HCBS providers, the FEA, and workers comply with critical incident requirements.

2.15.7.1.4.9 Conducting oversight, including but not limited to oversight of its staff, contract CHOICES HCBS providers, and the FEA, to ensure that the CONTRACTOR's policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

2.15.7.2 Behavioral Health Adverse Occurrences

2.15.7.2.1 Adverse occurrences shall include but not be limited to the following incidents when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit:

2.15.7.2.1.1 Suicide death

2.15.7.2.1.2 Non-suicide death

2.15.7.2.1.3 Death-cause unknown

2.15.7.2.1.4 Homicide

2.15.7.2.1.5 Homicide Attempt with significant medical intervention

2.15.7.2.1.6 Suicide Attempt with significant medical intervention

2.15.7.2.1.7 Allegation of Abuse/Neglect (Physical, Sexual, Verbal)

2.15.7.2.1.8 Accidental Injury with significant medical intervention

2.15.7.2.1.9 Use of Restraints/Seclusion (Isolation) requiring significant medical intervention; or

2.15.7.2.1.10 Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

2.15.7.3 The CONTRACTOR shall report to TENNCARE any death and any incident that could significantly impact the health or safety of a member (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.

2.15.7.4 As specified in Sections 2.30.12.7 and 2.30.12.8, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding all critical incidents and adverse occurrences.

32. Section 2.15 shall be amended by adding a new Section 2.15.8 as follows:

2.15.8 Provider Preventable Conditions

The CONTRACTOR shall comply with 42 CFR Part 438 requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §434.6(a)(12) and § 447.26. The CONTRACTOR shall submit all identified Provider Preventable Conditions in a form or frequency as described by TENNCARE.

33. Section 2.16.2 shall be deleted and replaced as follows:

2.16.2 The prohibition on enrollee marketing shall not apply to health education and outreach activities (see Section 2.7.4) that are described in the CONTRACTOR's TennCare approved Annual Community Outreach Plan.

34. Section 2.17.1.1 shall be deleted and replaced as follows:

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials). This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

35. Section 2.17.2.7 shall be amended by adding additional text as follows:

2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member. Alternative formats may include, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual enrollee. The CONTRACTOR shall have processes in place to ensure that alternative format material will be made available to the enrollee within forty five (45) days of a request;

36. Section 2.17.4.7.7 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

37. Section 2.18.5.3 shall be amended by deleting and replacing Section 2.18.5.3.14 and adding a new Section 2.18.5.3.15 as follows. The remaining Section shall be renumbered accordingly, including any references thereto.

2.18.5.3.14 Information for CHOICES HCBS providers regarding prohibition of facilitating CHOICES referrals with the expectation of being selected as the service provider or petitioning existing CHOICES members to change CHOICES providers (See Section 2.12.12.9);

2.18.5.3.15 Requirements regarding the prohibition of the reproduction and/or use of CHOICES and MFP materials and logos (See Sections 2.12.12.12 and 2.12.12.13).

38. Section 2.18.6.3.16 shall be amended by adding "and behavioral health" as follows:

2.18.6.3.16 Critical incident reporting and management for CHOICES HCBS and behavioral health providers;

39. Section 2.18.6 shall be amended by adding a new Section 2.18.6.9 and renumbering the remaining Section accordingly including any references thereto.

2.18.6.9 The CONTRACTOR shall provide documented and routine education and training to providers regarding proper billing.

40. Section 2.20.1 shall be deleted and replaced as follows and all references shall be updated accordingly.

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, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request.

2.20.1.5 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the CONTRACTOR dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

2.20.1.6 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.

2.20.1.7 The CONTRACTOR is prohibited from the repayment of funds paid by the CONTRACTOR to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:

2.20.1.7.1 Have been obtained by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or

2.20.1.7.2 Have been obtained by the States Recovery Audit Contractor (RAC) contractor; or

2.20.1.7.3 When the issue, services or claims that are the basis of the repayment are currently being investigated by the State of Tennessee, are the subject of pending Federal or State litigation, or are being audited by the TennCare RAC.

2.20.1.8 This prohibition described above in Section 2.20.1.7 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The CONTRACTOR shall check with the Bureau of TennCare, Program Integrity Unit before initiating any repayment of any program integrity related funds (See Section 2.20.1.7) to ensure that the repayment is permissible. In the event that the CONTRACTOR obtains funds in cases where repayment is prohibited under this section, the CONTRACTOR will return the funds to the provider.

2.20.1.9 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.

41. Section 2.20.2 shall be amended by adding the word ",subcontractors" after the word "CONTRACTOR" in Section 2.20.2.9 and by adding a new Section 2.20.2.13 as follows:

2.20.2.13 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section 2.12.9.36 and Section 3.16.5.1).

42. Sections 2.20.3.2.7 and 2.20.3.2.8 shall be amended by adding the word "Include" to the beginning of the sentence and change the following word "A" to "a".

43. Section 2.20.3.2 shall be amended by adding new Sections 2.20.3.2.2 and 2.20.3.2.14 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.20.3.2.2 Include a risk assessment of the CONTRACTOR's various fraud and abuse/program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment 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. The assessment shall also include a listing of the CONTRACTOR's top three vulnerable areas and shall outline action plans in mitigating such risks;

2.20.3.2.14 Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

44. The renumbered Section 2.20.3.2.12 shall be amended by deleting the word "and" at the end of the sentence and the renumbered Section 2.20.3.2.13 shall be amended by deleting "." and adding "; and" to the end of the sentence.

45. Section 2.20.3.6 shall be amended as follows:

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 both the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The CONTRACTOR shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.

46. Section 2.22.2.1 shall be deleted and replaced as follows:

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service (ensuring all billing information related to tax-reporting business entities and information related to individuals who provide services are properly reported on claims), date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track and report service use against benefit limits in accordance with a methodology set by TENNCARE.

47. Section 2.22.2 shall be amended by adding a new Section 2.22.2.6 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.22.2.6 For any entities to which the CONTRACTOR makes payment via electronic transfers, the CONTRACTOR shall have a signed EFT form that shall have 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section.

48. Section 2.22 shall be amended by adding a new Section 2.22.7 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.22.7 Monthly Focused Claims Testing

2.22.7.1 In addition to the claims payment accuracy testing procedures described in Section 2.22.6, the CONTRACTOR shall perform a monthly self test on the accuracy of claims processing based on claims judgmentally selected by TDCI. The maximum number of claims selected by TDCI each month will not exceed twenty-five (25), unless TDCI, at its discretion, determines a larger sample is warranted based on the results of the accuracy tests. The results reported by the CONTRACTOR are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by the CONTRACTOR or subcontractors.

2.22.7.2 The monthly focused claims testing procedures include:

2.22.7.2.1 The CONTRACTOR shall complete the attribute sheets provided by TDCI for each claim to be tested within thirty (30) calendar days of receipt from TDCI.

2.22.7.2.2 The CONTRACTOR shall submit a plan of correction as requested by TDCI.

49. The renumbered Section 2.22.8 shall be amended by adding a new Section 2.22.8.3 as follows and renumbering the remaining Section accordingly including any references thereto.

2.22.8.3 Identify improper payments made to invalid, missing, and/or mismatched NPIs, and/or TINs/EINs.

50. Section 2.24.4.2.4 shall be amended by deleting the reference to "Section 2.15.7.4" and replacing it with "Section 2.15.7.1.4".

51. Section 2.26.11 shall be deleted and replaced as follows:

2.26.11 **Assignability**

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

2.26.11.2 Subcontractors shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (EPLS) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

52. Section 2.27 shall be deleted and replaced as follows:

2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

2.27.1 TENNCARE and the CONTRACTOR shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended.

2.27.2 The CONTRACTOR warrants to TENNCARE that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Agreement including but not limited to the following:

2.27.2.1 Compliance with the Privacy Rule, Security Rule, and Notification Rule;

2.27.2.2 The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;

2.27.2.3 Timely Reporting of Violations in the Access, Use and Disclosure of PHI; and

2.27.2.4 Timely Reporting of Privacy and/or Security Incidents.

2.27.2.5 Failure to comply may result in actual damages that the State incurs as a result of the breach and liquidated damages in accordance with Section 4.20.

2.27.3 The CONTRACTOR warrants that it shall cooperate with TENNCARE, including cooperation and coordination with TENNCARE privacy officials and other compliance officers required by HIPAA and HITECH and their accompanying regulations, in the course of performance of the Agreement so that both parties will be in compliance with HIPAA and HITECH.

TENNCARE and the CONTRACTOR shall sign documents, including, but not limited to, business associate agreements, as required by HIPAA and HITECH, that are reasonably necessary to keep TENNCARE and the CONTRACTOR in compliance with HIPAA and HITECH.

2.27.4 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations.

2.27.5 In accordance with HIPAA/HITECH regulations, the CONTRACTOR shall, at a minimum:

2.27.5.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;

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

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

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

2.27.5.5 Report to TENNCARE's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;

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

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

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

2.27.5.9 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA/HITECH regulations upon request;

2.27.5.10 Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:

2.27.5.10.1 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.

2.27.5.11 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with this Section of this Agreement. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

2.27.5.12 Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;

2.27.5.13 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;

2.27.5.14 Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;

2.27.5.15 Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;

2.27.5.16 Track training of CONTRACTOR staff and employees and maintain signed acknowledgements by staff and employees of the CONTRACTOR's HIPAA/HITECH policies;

2.27.5.17 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations where permitted under the regulations;

2.27.5.18 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;

2.27.5.19 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to PHI and personally identifiable data within their organization;

2.27.5.20 Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased;

2.27.5.21 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;

2.27.5.22 Make available PHI in accordance with 45 CFR 164.524;

2.27.5.23 Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526; and

2.27.5.24 Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

2.27.6 The CONTRACTOR shall track all security incidents as defined by HIPAA/HITECH, and, as required by the HIPAA/HITECH Reports. The CONTRACTOR shall periodically report in summary fashion such security incidents.

2.27.7 TENNCARE and the CONTRACTOR are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of CONTRACTOR's information system, as defined by TCA 47-18-2107, the CONTRACTOR shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with TENNCARE's express written approval. The CONTRACTOR shall notify

TENNCARE's Privacy Office immediately upon becoming aware of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.

2.27.8 NOTIFICATION OF BREACH & NOTIFICATION OF PROVISIONAL BREACH. The CONTRACTOR shall notify TENNCARE's Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or *may* represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the CONTRACTOR, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the CONTRACTOR's system. This includes, but is not limited to, loss or *suspected* loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.

53. Section 2.28.2 and 2.28.3 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.

2.28.2.1 This person shall develop a CONTRACTOR non-discrimination compliance training plan within thirty (30) days of the implementation of this Agreement, to be approved by the Bureau of TennCare. This person shall be responsible for the provision of instruction regarding the plan to all CONTRACTOR staff within sixty (60) days of the implementation of this Agreement. This person shall be responsible for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of the implementation of this Agreement. The CONTRACTOR shall be able to show documented proof of such instruction.

2.28.3 The CONTRACTOR's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section 2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.

54. Section 2.30.3 shall be deleted and replaced as follows:

2.30.3 **Annual Community Outreach Plan**

The CONTRACTOR shall submit an *Annual Community Outreach Plan* no later than November 30 of each year for review and approval by TENNCARE. The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; community/health education events unrelated to TENNderCare; rationale for participating in these events; and a process for evaluating the benefits of the events.

55. Section 2.30.6 shall be amended by adding a new Section 2.30.6.8 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.30.6.8 Beginning April 2012, the CONTRACTOR shall submit a monthly *CHOICES Caseload and Staffing Ratio Report.*

2.30.6.8.1 The report shall reflect the weighted care coordinator-to-CHOICES member staffing ratios and care coordinator caseloads on the last business day of the month prior to the report submission (e.g. the report submitted in April 2012 will reflect the weighted caseloads and staffing ratios as they appeared on March 31, 2012);

2.30.6.8.2 The report shall include at a minimum;

2.30.6.8.2.1 The weighted average care coordinator-to CHOICES member staffing ratio; and

2.30.6.8.2.2 The weighted caseload of CHOICES member assignments to each individual care coordinator.

56. Section 2.30 shall be amended by adding a new Section 2.30.7 "LEFT BLANK INTENTIONALLY", renumbering the remaining Section accordingly including any references thereto and by deleting and replacing the renumbered Section 2.30.9 as "LEFT BLANK INTENTIONALLY.

57. The renumbered Section 2.30.11.2 shall be deleted and replaced as follows:

2.30.11.2 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred twenty (120) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

58. The renumbered Section 2.30.11.7 shall be deleted and replaced as follows:

2.30.11.7 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* (See Section 2.14.1.16.1) to TENNCARE no later than March 31st and September 30th each year identifying interventions initiated for members who exceeded the defined threshold for ED usage.

59. The renumbered Section 2.30.12 shall be amended by adding a new Section 2.30.12.5 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.30.12.5 The CONTRACTOR shall submit to TENNCARE by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported".

60. The renumbered Section 2.30.12 shall be amended by adding a new Section 2.30.12.8 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.30.12.8 The CONTRACTOR shall submit a quarterly Behavioral Health Adverse Occurrences Report in accordance with Section 2.15.7.2 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.8.1 The number of adverse occurrences, overall and by:

2.30.12.8.1.1 Date of occurrence

2.30.12.8.1.2 Type of adverse occurrence;

2.30.12.8.1.3 Location;

2.30.12.8.1.4 Provider name; and

2.30.12.8.1.5 Action Taken by Facility/Provider.

61. The renumbered Section 2.30.15.4 shall be deleted in its entirety and replaced as follows:

2.30.15.4 Effective July 1, 2012, the CONTRACTOR shall submit a quarterly *Disclosure Submission Rate report* which shall provide the percentage of providers for which the CONTRACTOR has obtained a complete and current disclosure form in accordance with 42 CFR 455, TennCare policies and procedures, and this Agreement (see Section 2.12.9.37). The rate shall be provided for all tax-reporting entities with billing activities during the prior quarter. The quarterly report shall include a companion listing which shall include all tax-reporting entities with reimbursement amounts received in the prior reporting quarter along with the disclosure status. For all subcontractors and providers with a signed contract and/or with billing activities, the CONTRACTOR shall maintain a minimum of ninety-five percent (95%) compliance on all entities excluding providers who bill under emergency provisions. Should the CONTRACTOR attain a disclosure rate below ninety-five percent (95%), the CONTRACTOR shall be subject to liquidated damages and shall submit a corrective action plan that shall address the root causes of the non–compliance.

62. The renumbered Section 2.30.15.5 shall be amended as follows:

2.30.15.5 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 Excluded Parties List System (EPLS), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board

63. The renumbered Section 2.30.17 shall be amended by adding a new Section 2.30.17.2 and the renumbered Section 2.30.17.4 shall be amended by adding the phrase "number of adjustments (including repayments)," as follows. The remaining Section shall be renumbered accordingly including any references thereto.

2.30.17.2 The CONTRACTOR shall submit a monthly *Focused Claims Testing Report.* The report shall include the results of the self test on the accuracy of claims processing based on claims that have been judgmentally selected by TDCI (see Section 2.22.7). The CONTRACTOR shall complete the attribute sheets provided by TDCI for each claim to be tested within thirty (30) calendar days of receipt from TDCI.

2.30.17.4 The CONTRACTOR shall submit a weekly *Claims Activity Report.* This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, number of adjustments (including repayments), and total amount paid by the categories of service specified by TENNCARE.

64. The renumbered Section 2.30.21 shall be deleted and replaced as follows:

2.30.21 HIPAA/HITECH Reports

The CONTRACTOR shall submit a *Privacy/Security Incident Report.* This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. Upon TENNCARE's request, the CONTRACTOR shall provide additional details within a reasonable amount of time. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

65. Section 3.9.2.5 and 3.9.2.6 shall be deleted and replaced as follows:

3.9.2.5 If TENNCARE has determined the CONTRACTOR is not in compliance with a requirement of this Agreement in any given month, TENNCARE may issue a written notice of deficiency and TENNCARE may retain the amount withheld for the month prior to TENNCARE identifying the compliance deficiencies.

3.9.2.6 The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies may at TENNCARE's discretion be applied in accordance with Section 3.9.2.1 as described above. If the CONTRACTOR has attained a two and one half percent (2.5%) withhold and TENNCARE subsequently determines the CONTRACTOR is not in compliance with a requirement of this Agreement, TENNCARE may provide written notice of such determination and TENNCARE may, at the discretion of TENNCARE, re-institute the retention of the withhold as described in Section 3.9.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected. These funds may not be distributed to the CONTRACTOR unless it is determined by TENNCARE the CONTRACTOR has come into compliance with the Agreement requirement(s) within six (6) months of TENNCARE identifying these deficiencies. For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies

which the CONTRACTOR has been given written notice of by TENNCARE, the withhold for the four (4) consecutive months will be paid to the CONTRACTOR upon TENNCARE determination that the deficiency(s) was corrected. However, any amounts withheld by TENNCARE for six (6) consecutive months for the same or similar compliance deficiency(s) may be permanently retained by TENNCARE on the first day after the sixth consecutive month period and may not be paid to the CONTRACTOR. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TENNCARE may declare the MCO ineligible for future distribution of the ten percent (10%) incentive withhold and may continue to permanently retain any amounts withheld by TENNCARE for six (6) consecutive months. Such ineligibility will continue for each month TENNCARE determines the same or similar specified deficiency(s) continues to exist. Once a CONTRACTOR corrects the deficiency(s), TENNCARE may reinstate the MCO's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TENNCARE determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the CONTRACTOR.

66. Section 3.16.1.1 shall be deleted and replaced as follows:

3.16.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed five billion, three hundred twenty four million, three hundred sixty one thousand, three hundred seventy six dollars ($5,324,361,376.00).

67. Section 3.16.5 shall be amended by adding a new Section 3.16.5.1 as follows and renumbering the remaining Section accordingly, including any references thereto.

3.16.5 Return of Funds and Deductions

3.16.5.1 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall report overpayments and, when it is applicable, return overpayments to TENNCARE within sixty (60) days from the date the overpayment is identified by the CONTRACTOR. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified by the CONTRACTOR may result in a penalty pursuant to state or federal law.

3.16.5.2 The CONTRACTOR shall refund to TENNCARE any overpayments due or funds disallowed pursuant to this Agreement within thirty (30) calendar days of the date of written notification from TENNCARE, unless otherwise authorized by TENNCARE in writing.

3.16.5.2 The State reserves the right to deduct from amounts which are or shall become due and payable to the CONTRACTOR under this or any Agreement or contract between the CONTRACTOR and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the CONTRACTOR.

68. Section 4.3 shall be amended by adding a new Section 4.3.2 as follows and renumbering the remaining Section 4.3 accordingly, including any references thereto.

4.3.2 42 CFR Part 438, Managed care, including but not limited to 438.6(f)(2)(i), compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of

payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and § 447.26 of this subchapter.

69. Section 4.4.8.2 shall be amended by adding a new Section 4.4.8.2.7 as follows and renumbering the remaining Section accordingly, including any references thereto.

4.4.8.2.7 Promptly make available all signed provider agreements/contracts, including historical agreements/contracts, to TENNCARE in PDF format. (The CONTRACTOR shall have the option to submit said agreements on an on-going basis during the term of this Agreement rather than at the end of this Agreement). Upon termination of this Agreement and completion of the CONTRACTOR's continuing obligations, the State will reserve all rights to pursue improper payments and false claims with the CONTRACTOR and/or directly with the CONTRACTOR's subcontractors and providers.

70. Section 4.20.2.2.6 shall be amended by adding a new Section 4.20.2.2.6.1 as follows:

4.20.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five hundred dollars ($500) per occurrence with any notice of deficiency.

4.20.2.2.6.1 In circumstances for which TENNCARE has applied this general liquidated damage to a notice of a deficiency that is related in any way to CHOICES care coordination processes and requirements which shall be determined by TENNCARE, the amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.

71. Sections 4.20.2.2.7, Items A.16, A.18, A.19,.A.20, A.21, A.22, A.23, the renumbered Items A.28, A.29, A.30, A.31, and Item C.7 shall be amended by adding a new paragraph to the end of the existing text in the Damage column as follows:

"These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement."

72. Section 4.20.2.2.7 shall be amended by deleting and replacing Items A.23 through A.26 and adding a new Item A.27 as follows and renumbering the remaining Items.

A.23	Failure to facilitate transfers between nursing facilities or to facilitate transitions between CHOICES Groups accordance with 2.9.6.9.1.1.5 and 2.9.6.9.2.1.18	$500 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

A.24	Failure by the CONTRACTOR to ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of TennCare enrollee PHI (See also ancillary Business Associate Agreement between the parties)	$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by CONTRACTOR's failure to comply with the terms of this Agreement, the CONTRACTOR shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.
A.25	Failure by the CONTRACTOR to execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (See ancillary Business Associate Agreement between the parties)	$500 per enrollee per occurrence
A.26	Failure by the CONTRACTOR to seek express written approval from TENNCARE prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement between the parties)	$1,000 per enrollee per occurrence

A.27	Failure by the CONTRACTOR to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (See also ancillary Business Associate Agreement between the parties)	$500 per enrollee per occurrence, not to exceed $10,000,000

73. Section 4.20.2.2.7 shall be amended by deleting and replacing Items B.15 and B.21 as follows:

B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.9.37 of this Agreement Failure to maintain complete and current disclosures/attestations for all providers excluding providers billing under emergency provisions	$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B. 92 to 95% Compliance - $5000 per each full percentage point below 95% Under 92% Compliance - $10,000 per each full percentage point below 95%

B.21	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17	$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% $10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% $20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% $50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% $100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

74. "Mental Health Case Management" Services in Attachment I shall be deleted and replaced as follows:

SERVICE	Mental Health Case Management

DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

The Case Management Society of America (CMSA) defines case management as a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1and 2a and 2b (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Team Intensive Approaches) Delivered by an		

Amendment 10 (cont.)

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Interdisciplinary Team		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2a* (Individual Intensive Approach) Delivered by a Single Case Manager	25 individuals:1 case manager	Three (3) contacts per month
Level 2b (Individual Approach) Delivered by a Single Case Manager	35 individuals:1 case manager	Two (2) contacts per month

The CONTRACTOR shall ensure that the following requirements are met:

1) All mental health case managers shall have, at a minimum, a bachelor's degree or be licensed as a Registered Nurse;
2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
4) A minimum of fifty-one percent (51%) of all mental health case management services should take place outside the case manager's office at the most appropriate setting;
5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management shall be rendered through a team approach. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below: *Assertive Community Treatment (ACT)*

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the ACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) No arbitrary time limit on receiving services;
8) Individualized treatment, support and rehabilitation services;
9) Twenty-four (24) hour a day availability of services; and
10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the "imminent" risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to

provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2a and Level 2b

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

Where available, peer support might be used as an adjunct to the case manager in monitoring the service recipient prior to discharge from Level 2 case management. However, at no time should peer support in the form of Certified Peer Specialists, or any other form, become a substitute for case managers in the delivery of case management services.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

75. 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.

76. Attachment VIII shall be amended by deleting and replacing the list of DELIVERABLE ITEMS as follows:

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Policies and procedures for patient liability that ensure compliance with Section 2.6.7.2

6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3

7. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.4

8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6

9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7

10. Disease management program policies and procedures that ensure compliance with Section 2.8

11. Service coordination policies and procedures that ensure compliance with Section 2.9.1

12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3

14. Transition of care policies and procedures that ensure compliance with Section 2.9.4

15. MCO case management policies and procedures that ensure compliance with Section 2.9.5

16. Care coordination policies and procedures that ensure compliance with Section 2.9.6

17. Policies and procedures for consumer direction of eligible CHOICES HCBS that ensure compliance with Section 2.9.7

18. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section 2.9.9

19. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.10.2 to ensure compliance with Section 2.9.9

20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.10

21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.11

22. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.12

23. Identification of members serving on the claims coordination committee in accordance with Section 2.9.12.5.3

24. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.13

25. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.15

26. Policies and procedures regarding non-covered services that ensure compliance with Section 2.10

27. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

28. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

29. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

30. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8

31. Policies and procedures that ensure compliance with notice requirements in Section 2.11.9

32. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.9.2

33. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

34. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.9.54)

35. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.9)

36. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.9)

37. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.10.1

38. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9

39. Information on PCP profiling as requested by TENNCARE (see Section 2.14.9)

40. QM/QI policies and procedures to ensure compliance with Section 2.15

41. Copy of signed contract with NCQA approved vendor to perform CAHPS as required by Section 2.15.5

42. Copy of signed contract with NCQA approved vendor to perform HEDIS audit as required by Section 2.15.5

43. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.5.1)

44. HEDIS BAT as required by Section 2.15.6

45. Copy of signed NCQA survey contract as required by Section 2.15.5.1

46. Notice of date for ISS submission and NCQA on-site review as required by Section 2.15.5.1

47. Notice of final payment to NCQA as required by Section 2.15.5.1

48. Notice of submission of ISS to NCQA as required by Section 2.15.5.1

49. Copy of completed NCQA survey and final report as required by Section 2.15.5.1

50. Notice of any revision to NCQA accreditation status

51. Policies and procedures regarding critical incident management and reporting to ensure compliance with Section 2.15.7.1

52. Policies and procedures regarding behavioral health adverse occurrence reporting to ensure compliance with Section 2.15.7.2

53. Report critical incidents or adverse occurrences to TENNCARE within twenty-four (24) hours pursuant to Sections 2.15.7.1, 2.15.7.2, and 2.15.7.3

54. Provider Preventable Conditions Reporting (see Section 2.15.8)

55. If applicable, information on the use of the name of the CONTRACTOR's TennCare MCO pursuant to Section 2.16.3

56. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletters, identification card, and provider directory along with any required supporting materials

57. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

58. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

59. Provider service and phone line policies and procedures that ensure compliance with Section 2.18.4

60. Description of 24/7 ED Assistance Line (see Section 2.18.4.7)

61. Provider handbook that is in compliance with requirements in Section 2.18.5

62. Provider education and training plan and materials that ensure compliance with Section 2.18.6

63. Provider relations policies and procedures in compliance with Section 2.18.7

64. Protocols regarding one-on-one assistance to long-term care providers that ensure compliance with Section 2.18.7.2

65. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.3)

66. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

67. FEA education and training plan and materials that ensure compliance with Section 2.18.9

68. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.10

69. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

70. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

71. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

72. Fraud and abuse compliance plan (see Section 2.20.3)

73. A risk assessment annually and "as needed" (see Section 2.20.3.2.2)

74. TPL policies and procedures that ensure compliance with Section 2.21.4

75. Accounting policies and procedures that ensure compliance with Section 2.21.7

76. Proof of insurance coverage (see Section 2.21.8)

77. Executed agreement for audit accounts that contains the required language (see Section 2.21.11)

Amendment 10 (cont.)

78. Claims management policies and procedures that ensure compliance with Section 2.22

79. Internal claims dispute procedure (see Section 2.22.5)

80. EOB policies and procedures to ensure compliance with Section 2.22.8

81. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

82. Proposed approach for remote access in accordance with Section 2.23.6.10

83. Information security plan as required by Section 2.23.6.11

84. Notification of Systems problems in accordance with Section 2.23.7

85. Systems Help Desk services in accordance with Section 2.23.8

86. Notification of changes to Systems in accordance with Section 2.23.9

87. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

88. Notification of changes to membership of CHOICES Advisory Group and current membership lists in accordance with Section 2.24.3

89. An abuse and neglect plan in accordance with Section 2.24.4

90. Medical record keeping policies and procedures that ensure compliance with Section 2.24.6

91. Subcontracts (see Section 2.26)

92. HIPAA policies and procedures that ensure compliance with Section 2.27

93. Notification of breach and provisional breach in accordance with Section 2.27

94. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27

95. Non-discrimination policies and procedures as required by Section 2.28

96. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

97. Changes to key staff as required by Section 2.29.1.2

98. Staffing plan as required by Section 2.29.1.8

99. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.9

100. Background check policies and procedures that ensure compliance with Section 2.29.2.1

101. List of officers and members of Board of Directors (see Section 2.29.3)

Amendment 10 (cont.)

102. Changes to officers and members of Board of Directors (see Section 2.29.3)

103. Eligibility and Enrollment Data (see Section 2.30.2.1)

104. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)

105. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)

106. Information on members (see Section 2.30.2.4)

107. Annual Community Outreach Plan (see Section 2.30.3)

108. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)

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

110. Behavioral Health Crisis Response Report (see Section 2.30.4.3)

111. TENNderCare Report (see Section 2.30.4.4)

112. Disease Management Update Report (see Section 2.30.5.1)

113. Disease Management Report (see Section 2.30.5.2)

114. Disease Management Program Description (see Section 2.30.5.3)

115. MCO Case Management Program Description (see Section 2.30.6.1.1)

116. MCO Case Management Services Report (see Section 2.30.6.1.2)

117. MCO Case Management Update Report (see Section 2.30.6.1.3)

118. Status of Transitioning CHOICES Member Report (see Section 2.30.6.2)

119. CHOICES Nursing Facility Diversion Activities Report (see Section 2.30.6.3)

120. CHOICES Nursing Facility to Community Transition Report (see Section 2.30.6.4)

121. CHOICES HCBS Late and Missed Visits Report (see Section 2.30.6.5)

122. CHOICES Consumer Direction of eligible CHOICES HCBS Report (see Section 2.30.6.6)

123. CHOICES Care Coordination Report (see Section 2.30.6.7)

124. Monthly CHOICES Caseload and Staffing Ratio Report (see Section 2.30.6.8)

125. Quarterly MFP Participants Report (see Section 2.30.6.9)

126. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.10)

127. Pharmacy Services Report (see Section 2.30.6.11)

128. Pharmacy Services Report, On Request (see Section 2.30.6.12)

129. Provider Enrollment File (see Section 2.30.8.1)

130. Provider Compliance with Access Requirements Report (see Section 2.30.8.2)

131. PCP Assignment Report (see Section 2.30.8.3)

132. Report of Essential Hospital Services (see Section 2.30.8.4)

133. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness (see Section 2.30.8.5)

134. Quarterly Behavioral Health Appointment Timeliness Summary Report (see Section 2.30.8.6)

135. CHOICES Qualified Workforce Strategies Report (see Section 2.30.8.7)

136. FQHC Reports (see Section 2.30.8.8)

137. Related Provider Payment Report (see Section 2.30.10.1)

138. Check Run Summaries Report (see Section 2.30.10.2)

139. Claims Data Extract Report (see Section 2.30.10.3)

140. Reconciliation Payment Report (see Section 2.30.10.4)

141. Administrative Services Only Invoice Report (See Section 2.30.10.5)

142. UM program description, work plan, and evaluation (see Section 2.30.11.1)

143. Cost and Utilization Reports (see Section 2.30.11.2)

144. Cost and Utilization Summaries (see Section 2.30.11.3)

145. Identification of high-cost claimants (see Section 2.30.11.4)

146. CHOICES Utilization Report (see Section 2.30.11.5)

147. Referral Provider Listing and supporting materials (see Section 2.30.11.6)

148. Emergency Department Threshold Report (see Section 2.30.11.7)

149. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.12.1)

150. Report on Performance Improvement Projects (see Section 2.30.12.2)

151. NCQA Accreditation Report (see Section 2.30.12.3)

152. NCQA revaluation of accreditation status based on HEDIS scores (see Section 2.30.12.4)

Amendment 10 (cont.)

153. Medicaid HEDIS measures marked as "Not Reported" (see Section 2.30.12.5)

154. Reports of Audited CAHPS Results and Audited HEDIS Results (see Section 2.30.12.6)

155. CHOICES HCBS Critical Incidents Report (see Section 2.30.12.7)

156. Behavioral Health Adverse Occurrences Report (see Section 2.30.12.8)

157. Member Services, Provider Services, and Utilization Management Phone Line Report (see Section 2.30.13.1.1)

158. 24/7 Nurse Triage Line Report (see Section 2.30.13.1.2)

159. ED Assistance Tracking Report (see Section 2.30.13.1.3)

160. Translation/Interpretation Services Report (see Section 2.30.13.3)

161. Provider Satisfaction Survey Report (see Section 2.30.13.4)

162. Provider Satisfaction Survey Report and CHOICES Provider Satisfaction Survey Report (see Sections 2.30.13.4 and 2.30.13.5)

163. Member Complaints Report (see Section 2.30.14)

164. Fraud and Abuse Activities Report (see Section 2.30.15.1)

165. Policies in compliance with Section 1902(a)(68) of the Social Security Act (see Section 2.30.15.3)

166. Disclosure Submission Rate Report (see Section 2.30.15.4)

167. Program Integrity Exception List Report (see Section 2.30.15.5)

168. List of Involuntary Terminations Report (see Section 2.30.15.6)

169. Recovery and Cost Avoidance Report (see Section 2.30.16.1.1)

170. Other Insurance Report (see Section 2.30.16.1.2)

171. Medical Loss Ratio (MLR) Report (see Section 2.30.16.2.1)

172. Ownership and Financial Disclosure Report (see Section 2.30.16.2.2)

173. Annual audit plan (see Section 2.30.16.2.3)

174. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.16.3.1)

175. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.16.3.2)

176. Annual Financial Report (to TDCI) (see Section 2.30.16.4.3)

177. Quarterly Financial Report (to TDCI) (see Section 2.30.16.3.4)

178. Audited Financial Statements (to TDCI) (see Section 2.30.16.3.5)

179. Claims Payment Accuracy Report (see Section 2.30.17.1)

180. EOB Report (see Section 2.30.17.2)

181. Claims Activity Report (see Section 2.30.17.3)

182. CHOICES Cost Effective Alternatives Report (see Section 2.30.17.4)

183. Systems Refresh Plan (see Section 2.30.18.1)

184. Encounter Data Files (see Section 2.30.18.2)

185. Electronic version of claims paid reconciliation (see Section 2.30.18.3)

186. Information and/or data to support encounter data submission (see Section 2.30.18.4)

187. Systems Availability and Performance Report (see Section 2.30.18.5)

188. Business Continuity and Disaster Recovery Plan (see Section 2.30.18.6)

189. Reports on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee (see Section 2.30.19.1)

190. Report on the Activities of the CONTRACTOR's CHOICES Advisory Group (see Section 2.30.19.2)

191. Subcontracted claims processing report (see Section 2.30.20.1)

192. HIPAA/HITECH Report (*Privacy/Security Incident Report*) (see Section 2.30.21)

193. Non-discrimination policy (see Section 2.30.22.1)

194. Summary Listings of Servicing Providers (see Section 2.30.22.2)

195. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.22.3)

196. Non-Discrimination Compliance Report (see Section 2.30.22.4)

197. Disclosure of conflict of interest (see Section 2.30.23.1)

198. Attestation Re: Personnel Used in Contract Performance (see Section 2.30.23.2)

199. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1

200. Return of funds in accordance with Section 3.16.5

201. Termination plan in accordance with Section 4.4.8.2.8

202. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI

77. Attachment VI shall be deleted and replaced as follows:

ATTACHMENT VI

FORMS FOR REPORTING FRAUD AND ABUSE
POTENTIAL FRAUD ALLEGATION REFERRAL FORM
(template with sample data)

DATE: Month/Day/Year

TO: Office of Program Integirty

FROM: Your MCE Name

Contact Person: 1st & Last name; Telephone; EMail;

SUBJECT (ENTITY/NAME/SPECIALTY):
ABC Clinic, John Smith MD, Family Practice

SUBJECT ADDRESS/TELEPHONE:
100 Great Circle Rd, TN 37234 Phone: Fax:

PROVIDER INFORMATION(S):
HealthPlan IDs: 123456789 (Clinic) and 12345 (John Smith)
Medicaid ID(s): 7654321 (Clinic) and 9876543 (John Smith)
NPI(s): 1234567890 (Clinic) and 2345678900 (John Smith)
License – 1001 (John Smith)

DEA – 12345 (John Smith)
Tax ID – 621039594; SSN (2345678)

PROVIDER OPERATING REGION: East TN

PROVIDER INCOME:
$374,729 (April 2, 2007 – February 7, 2011)

DATES OF SERVICE AUDITED:
November 1, 2009 – November 9, 2010

OVERPAYMENT IDENTIFIED:
$ 31,861

Amendment 10 (cont.)

ALLEGATION:
Provider is allegedly billing an excessive number of services per day.

SOURCE/PREDICATION:
Data analysis internal lead from the Medicaid Plan

PROCEDURE CODE and MODIFIERS: 99214 – Office/outpatient visit for the evaluation and mgmt of an estab patient Mod 25 – A significant, separately identifiable service by the same physician on the same day of the procedure or other service.
Mod 59 – Distinct procedural service is distinct and or independent from other services performed on same day. Identifies procedures not normally reported together.

BILLING ENTITY:
Payments are made to the group via EFT.

MEDICAL RECORD TYPE:
Hard copy, hand written

SUMMARY OF PRELIMINARY INVESTIGATION ACTIONS:
Sampling:
A sample for 99214s with modifiers 25 and/or 59 for dates of service 11/1/0911/9/10 was generated. The universe size was 430 whereas a sample 30 of dates of service was pulled. A total of $100,000 was paid to the universe.

Medical Record Review and Findings:
On January 15, 2010 the medical record review was completed by an internal certified professional coder (CPC). There were a total of 138 services reviewed. The following is a summary of the services:

Service not allowed because documentation does not support service	4
Service line not allowed appears to be duplicate	1
Service not audited because documentation not provided	7
Procedure 96372 not allowed because reimbursement is included in EM CPT	16
Level of service not supported in documentation down code 99214 to 99213	24
Level of service not supported in documentation down code 99214 to 99212	1
Services appropriate for payment	85
Total Number of Services Audited	138

Modifier 25 was appended to the E/M services 97% of the time. It is inappropriate to append this modifier to an E/M service when it is billed in conjunction with laboratory services; 13 services were denied based on this rule.

Modifier 59 was appended on all ancillary codes (other than J codes) 100% of the time. It did not appear to be appropriately used in any instances. For example, claims for the therapeutic, prophylactic, or diagnostic injection and infusions (CPT 96365 or CPT 96372) that were appended with modifier 59 were denied 16 times.

Under certain circumstances, it may be necessary to indicate that a procedure of service was distinct or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. However, when another already established modifier is appropriate it should be used rather than modifier 59, only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: it is not necessary to appended modifier 59 to multiple laboratory services as it does not meet the circumstances stated above.

PRIOR EDUCATIONS:
None recorded

PREPAYMENT REVIEW:
None

INTERAGENCY CONTACT:
None

ADDITIONAL SUBJECT INFORMATION:

John Smith has hospital privileges at ABC Community Hospital.

DISCLOSURE OF OWNERSHIP and CONTROL:
John Smith owns 100% of the entity.

DETERMINATION:
Based on the medical record review it has been determined that the provider is abusing "modifier 25 and 59" in order to have add on services reimbursed that are typically already covered in the reimbursement of the E/M code.

RECOMMENDATION:
Petition for the Health Plan to pursue administratively by issuing/implementing:

Initiate pre payment review
Demand letter for repayment
Educate the provider on proper billing and medical record documentation.
Initiate a Corrective Action Plan with the provider
Continued monitoring of the provider's billing after notification of overpayment.

Amendment 10 (cont.)

TennCare Recommended MCC Referral Protocol:

1) the submission of documents related to the provider fraud and abuse referral should be via TennCare SFTP server
(path: tncare.sftp.state.tn.us/tncare/MCC###/orr/OPI/in) with password protections on documents;
2) concurrently, a notice of submission should be e-mailed to
ProgramIntegrity.TennCare@tn.gov with a subject line stating "MCC### Notice of Referral Submission via SFTP"
along with password notices on opening documents.

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting — recipient name or name of individual suspected of fraud

Other Names Used (If known) — alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable) — SSN, if known — DOB, if known

SSN, if known — DOB, if known

Spouse's Name (if applicable)

Street Address — physical address

Apartment #

City, State, Zip — city state zip

Other Addresses Used

Home Phone Number

area code

Work Phone Number (Please include)

area code

Employer's Name

Employer's Address

Employer's Phone #

area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care Contractor of this problem? ☐ Yes ☐ No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? ☐ No ☐ Yes name phone dept/ business

Requesting Drug Profile ☐ Yes ☐ No Have already received drug profile ☐ Yes ☐ No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228
FRAUD TOLL FREE HOTLINE 1-800-433-3982 •FAX (615) 256-3852

E-Mail Address: www.tennessee.gov/tenncare (follow the prompts that read "Report Fraud Now")

78. **Attachment VI shall be amended by deleting the performance standard for Non-IMD Inpatient Use in its entirety.**

79. **Attachment IX, Exhibit I shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".**

80. **The first two populations listed in Attachment IX, Exhibit K shall be deleted and replaced as follows:**

- Medicaid (Child and Adult)
- Uninsured (Child and Adult)

81. **Item 14 of Exhibit A of Attachment XI shall be deleted and replaced as follows:**

14. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with mental retardation. DIDD is a division of the Tennessee Department of Finance and Administration.

82. **Attachment XII shall be amended by adding a new Exhibit G as follows:**

EXHIBIT G
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 579.73
	Age 1 - 13	$ 94.98
	Age 14 - 20 Female	$ 231.61
	Age 14 - 20 Male	$ 141.55
	Age 21 - 44 Female	$ 385.02
	Age 21 - 44 Male	$ 241.91
	Age 45 – 64	$ 400.35
	Age 65 +	$ 470.88
Uninsured/Uninsurable	Age Under 1	$ 579.73
	Age 1 - 13	$ 85.04
	Age 14 - 19 Female	$ 119.19
	Age 14 – 19 Male	$ 124.86
Disabled	Age < 21	$ 1,322.00
	Age 21 +	$ 956.64
Duals/Waiver Duals	All Ages	$ 206.01
CHOICES Rate	CHOICES Duals	$ 4,077.79
	CHOICES Non-Duals	$ 5,667.52

Amendment 10 (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 January 1, 2012.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A Emkes /cb
Mark Emkes
Commissioner

DATE: 11/23/2011

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: N/A - Electronically Approved
Mark Emkes
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: N/A - Electronically Approved
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
Brian Kelsey, Ken Yager
Eric Stewart
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Curtis Johnson, Vice-Chairman
Representatives
Tommie Brown, David Shepard
Jim Coley, Tony Shipley
Charles Curtiss, Curry Todd
Johnny Shaw, Mark White
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

TO: The Honorable Mark Emkes, Commissioner
Department of Finance and Administration

FROM: Bill Ketron, Chairman, Fiscal Review Committee BK
Curtis Johnson, Vice-Chairman, Fiscal Review Committee

DATE: August 24, 2011

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 8/23/11)

RFS# 318.66-051 (Edison # N/A)
Department: Finance & Administration/Bureau of TennCare
Vendor: UnitedHealthCare Plan of the River Valley, Inc.
Summary: The vendor is responsible for physical and behavioral health services for TennCare enrollees in the Middle Tennessee region. The proposed amendment implements the Money Follows the Person Rebalancing Demonstration grant, and provides guidance to the vendor regarding crisis services and other behavioral health services.
Current maximum liability: $4,335,155,541
Proposed maximum liability: $4,335,155,541

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

cc: The Honorable Darin Gordon, Deputy Commissioner
Ms. Jessica Robertson, Chief Procurement Officer
Mr. Robert Barlow, Director, Office of Contracts Review

State of Tennessee
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

Bill Haslam
Governor

Mark A. Emkes
Commissioner

July 29, 2011

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

Attention: Ms. Leni Chick

RE: Bureau of TennCare Managed Care Organization Contract Amendments (7)

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments. These amendments are necessary to implement the Money Follows the Person Rebalancing Demonstration grant which has been awarded to TennCare by the Centers for Medicare and Medicaid Services (CMS). The grant will assist the State in identifying and assisting persons in institutions transition to a more cost-effective care in the community, and will support the State's continued efforts toward rebalancing its long term care system. These amendments also include language that will provide the MCO guidance regarding Crisis Services as well as various other Behavioral Health services, including specific clarification allowing licensed RNs to provide behavioral health case management. These amendments do not represent an increase in contract funding.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-26
AMERIGROUP Tennessee, Inc.	FA-07-16936-09
UnitedHealthCare Plan of River Valley, Inc.	FA-07-16937-09
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-06
Volunteer State Health Plan (West Region)	FA-08-24978-06
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-06
Volunteer State Health Plan (East Region)	FA-08-24983-06

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:	615-507-6415
*Original Contract Number:	FA-07-16937-00	*Original RFS Number:	318.66-051
Edison Contract Number: *(if applicable)*	N/A	Edison RFS Number: *(if applicable)*	N/A
*Original Contract Begin Date:	August 15, 2006	*Current End Date:	December 31, 2014

Current Request Amendment Number: *(if applicable)*	9
Proposed Amendment Effective Date: *(if applicable)*	October 1, 2011
*Department Submitting:	Department of Finance and Administration
*Division:	Bureau of TennCare
*Date Submitted:	July 29, 2011
*Submitted Within Sixty (60) days:	Yes
If not, explain:	NA
*Contract Vendor Name:	UnitedHealthCare Plan of the River Valley, Inc. (Middle Region)
*Current Maximum Liability:	$4,335,155,541.00

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

FY:2007	FY:2008	FY:2009	FY:2010	FY2011	FY 2012
$174,870,888	$699,483,574	$699,483,574	$782,905,835	$989,205,835	$989,205,835.00

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

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY 2011	FY
$ 108,816,203.00	$526,120,392.00	$ 573,634,106.00	$729,187,454.49	$1,051,885,932.05	$

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:	$1,391,950,970	Federal:	$2,943,204,571.00
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment #1 – 1/1/2007	Scope clarification relating to service thresholds, fraud and abuse compliance, semi-annual reporting timelines, and quarterly reporting of PCP visits per member. Language added to address requirements for Notification of Legal Action Against the Contractor and Prohibition of Illegal Immigrants
Amendment #2 – 7/1/2007	Contract language modifications and/or clarification relating to National Provider Identification requirements; Department of Education Project TEACH policies update; LEP provisions and Teen Newsletter requirements; PCP and emergency room visits reporting; emergency department utilization, disease management and case management, nurse triage 24/7 line and NCQA reporting; NCQA requirements; and general housekeeping revisions.
Amendment #3 – 4/1/2008	Add funding for FY 2009. Contract language modifications and/or clarification relating to quality standards of Non Emergency Medical Transportation; Cost Effective Alternative Services; Pay for Performance Incentives; EPSDT/Prenatal Notification; Reporting requirements for provider networks; NCQA requirements; requirements for weekly reporting; update risk targets; and Obesity DM program. Update to the rates for individual services to reflect a change in rate tables beginning April 1, 2008.
Amendment #4 – 09/01/2009	Provided language to implement the Long-Term Care Choices Act of 2008, complied with Mental Health Parity Act, provides clarification language to the contract, streamline reporting to enhance timeframes as well as review and analysis for consistency with NCQA reporting requirements.
Amendment #5 – March 1, 2010	Provided language changes to effectively implement the Long-Term Care Choices Act of 2008, and provide term extension and funding to support the extension.
Amendment #6 – July 1, 2010	Provided language relating to enforcement of Annual Coverage Assessment Act of 2010 and clarifications of Long-Term care reporting.
Amendment #7 – January 1, 2011	Address Program Integrity clarifications, Performance measures, CHOICES requirement clarifications, and update risk adjustment language modifications.
Amendment #8 – July 1, 2011	Clarification of CHOICES Requirements and credentialing Requirements; Clarification of Disease Management and NCQA Requirements; Revise Behavioral Health Monitoring Reports; Update Capitation Rates, and Term Extension and provide funding to support the term extension for FY '12.

Method of Original Award: (*if applicable*)	RFP

Supplemental Documentation Required for Fiscal Review Committee

*What were the projected costs of the service for the entire term of the contract prior to the 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:

Supplemental Documentation Required for Fiscal Review Committee

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.

UnitedHealthCare Plan (Americhoice) - Middle
FY 2011

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00158201	0000021799	70,740,671.09	7/2/2010
31865	00158204	0000021799	6,263,040.64	7/2/2010
31865	00173116	0000021799	71,151,938.06	8/6/2010
31865	00173119	0000021799	6,359,961.93	8/6/2010
31865	00181526	0000021799	11,836,788.90	8/23/2010
31865	00181527	0000021799	6,909,314.39	8/23/2010
31865	00178460	0000021799	61,911.29	8/31/2010
31865	00178459	0000021799	61,971.52	9/1/2010
31865	00178462	0000021799	72,814.47	9/1/2010
31865	00186274	0000021799	74,918,007.33	9/3/2010
31865	00186277	0000021799	6,220,403.67	9/3/2010
			254,596,823.29	
31865	00199537	0000021799	73,251,566.34	10/1/2010
31865	00199540	0000021799	6,461,845.29	10/1/2010
31865	00217255	0000021799	76,597,272.92	11/5/2010
31865	00217258	0000021799	6,994,599.71	11/5/2010
31865	00230054	0000021799	71,853,299.66	12/3/2010
31865	00230057	0000021799	6,850,120.36	12/3/2010
31865	00243065	0000021799	73,232,783.15	12/30/2010
31865	00243068	0000021799	6,584,392.18	12/30/2010
			321,825,879.61	
31865	00245567	0000021799	24.30	1/10/2011
31865	00248818	0000021799	605,600.00	1/14/2011
31865	00260938	0000021799	72,718,947.87	2/2/2011
31865	00260941	0000021799	6,623,413.09	2/2/2011
31865	00264738	0000021799	4,500.00	2/11/2011
31865	00277667	0000021799	72,658,495.99	3/4/2011
31865	00277670	0000021799	6,010,297.46	3/4/2011
31865	00285815	0000021799	500.00	3/18/2011
			158,621,778.71	

UnitedHealthCare Plan (AmeriChoice) - Middle FY 2011 (Continued)

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00297109	0000021799	77,226,527.58	4/1/2011
31865	00313437	0000021799	82,229,831.05	5/6/2011
31865	00313440	0000021799	18,698.13	5/6/2011
31865	00320306	0000021799	26,458.03	5/20/2011
31865	00320307	0000021799	(16,360.18)	5/20/2011
31865	00327196	0000021799	78,181,173.95	6/3/2011
31865	00327199	0000021799	2,157.82	6/3/2011
31865	00341555	0000021799	79,171,380.00	6/30/2011
31865	00341557	0000021799	1,584.06	6/30/2011
			316,841,450.44	

FY 2011 TOTAL **$1,051,885,932.05**

UnitedHealthCare Plan (Americhoice) - Middle

FY 2010

Pre-Edison Payments:

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

Edison Payments:

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00006784	0000021799	48,582,237.33	10/5/2009
31865	00006787	0000021799	6,193,643.53	10/5/2009
31865	00015655	0000021799	44,267,315.17	11/6/2009
31865	00015658	0000021799	5,480,859.10	11/6/2009
31865	00022040	0000021799	42,961,566.23	12/7/2009
31865	00022043	0000021799	5,449,527.21	12/7/2009
31865	00038454	0000021799	40,000.00	12/24/2009
			152,975,148.57	
31865	00051202	0000021799	44,449,762.28	1/8/2010
31865	00051205	0000021799	5,997,241.10	1/8/2010
31865	00068252	0000021799	44,025,304.75	2/5/2010
31865	00068255	0000021799	5,514,146.11	2/5/2010
31865	00086763	0000021799	62,590,461.23	3/5/2010
31865	00086766	0000021799	5,701,541.32	3/5/2010
			168,278,456.79	

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

Unit	Voucher ID	Vendor ID	Amount Pd	Pymnt Date
31865	00104917	0000021799	82,612,990.02	4/2/2010
31865	00104920	0000021799	8,643,743.79	4/2/2010
31865	00108122	0000021799	21,000,580.09	4/2/2010
31865	00103799	0000021799	352,048.25	4/6/2010
31865	00125595	0000021799	69,049,286.19	5/7/2010
31865	00125598	0000021799	6,310,699.70	5/7/2010
31865	00141601	0000021799	70,623.80	6/3/2010
31865	00141602	0000021799	64,266.91	6/3/2010
31865	00141603	0000021799	72,129.62	6/3/2010
31865	00142689	0000021799	64,652,898.59	6/4/2010
31865	00142692	0000021799	5,927,148.95	6/4/2010
			258,756,415.91	

FY 2010 TOTAL **$729,187,454.49**

MCO 031 AMERICHOICE MIDDLE

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

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 – 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

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

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

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

ATTACHMENT X

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

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

125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".

126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".

127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

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

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

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED

COMMISSIONER OF FINANCE & ADMINISTRATION

Request Tracking #	31866-00051
Procuring Agency	Department of Finance and Administration Bureau of TennCare
Contractor	UnitedHealthCare Plan of the River Valley, Inc.
Contract #	FA-07-16937-00
Proposed Amendment #	9
Edison ID #	NA

Contract Begin Date	August 15, 2006
Current Contract End Date *– with ALL options to extend exercised*	December 31, 2014
Proposed Contract End Date *– with ALL options to extend exercised*	December 31, 2014
Current Maximum Contract Cost *– with ALL options to extend exercised*	$4,335,155,541.00
Proposed Maximum Contract Cost *– with ALL options to extend exercised*	$ 4,335,155,541.00
Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	X Not Applicable ☐ Attached
eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging service*	X Not Applicable ☐ Attached
Human Resources Support *– state employee training service*	X Not Applicable ☐ Attached

Explanation Need for the Proposed Amendment

This contract is a competitively procured contract providing medical and behavioral services to TennCare enrollees. This amendment is necessary to implement the Money Follows the Person Rebalancing Demonstration grant which has been awarded to TennCare by the Centers for Medicare and Medicaid Services (CMS). The grant will help the State identify and assist persons in institutions in transitioning to more cost-effective care in the community, and will support the State's continued efforts

Request Tracking #	31866-00051

toward rebalancing its long term care system. The amendment also includes language that will provide the MCOs guidance regarding Crisis Services as well as various other Behavioral Health services with a specific clarification that licensed RNs may provide behavioral health case management. This amendment does not represent an increase in contract funding.

Name & Address of the Contractor's 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

Evidence Contractor's Experience & Length Of Experience Providing the Service

UnitedHealthcare Plan of the River Valley, Inc. is an operating division of UnitedHealth Group, the largest single health carrier in the United States. They are a recognized leader in the health and well-being industry, and delivers products and services to approximately 73 million Americans. UHC's nationwide network includes 570,000 physicians (and other care professionals) and 4,800 hospitals and their pharmaceutical management programs provide more affordable access to drugs for 15 million people. UnitedHealth Group made significant investments in research and development, technology and business process improvements, which led to changes that are improving the way care is delivered and administered across the entire industry. The Bureau of TennCare released an RFP and identified UnitedHealthCare Plan of the River Valley, Inc. as one of two (2) health care plans to provide services to TennCare enrollees in the Middle Tennessee Region.

Efforts to Identify Reasonable, Competitive, Procurement Alternatives

The Bureau of TennCare released a Request for Proposal which resulted in a competitively procured contract to integrate the provision of both Physical and Behavioral Health services to TennCare Enrollees in the Middle Tennessee Region. This amendment adds language relevant to the Money Follows the Person Rebalancing Demonstration grant which has been awarded to TennCare by the Centers for Medicare and Medicaid Services (CMS).

Justification – *specifically explain why non-competitive negotiation is in the best interest of the state*

This competitively procured contract is being amended to implement the Money Follows the Person Rebalancing Demonstration grant which has been awarded to TennCare by the Centers for Medicare and Medicaid Services (CMS). The grant will help the State identify and assist persons in institutions in transitioning to more cost-effective care in the community, and will support the State's continued efforts toward rebalancing its long term care system. This amendment also includes language that will provide the MCOs guidance regarding Crisis Services as well as various other Behavioral Health services with a specific clarification that licensed RNs may provide behavioral health case management. No additional funds are associated with this amendment. The approval by the Commissioner of Finance and Administration is greatly appreciated.

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances.*

Mark C. Emke 7/22/11

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
31866-00051	FA-07-16937-09
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,134.00	$ 655,180,701.00			$ 989,205,835.00
TOTAL:	$ 1,391,950,970.00	$ 2,943,204,571.00	$ -	$ -	$ 4,335,155,541.00

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012	$ 989,205,835.00	
TOTAL:	$ 4,335,155,541.00	$ -
End Date	December 31, 2014	

State Agency Fiscal Contact & Telephone #

Scott Pierce 507-6415

State Agency Budget Officer Approval

Scott

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)

Mark A. Emkey

ABS

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

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg.ID.GG.GU) [ ] Other

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

AMENDMENT NUMBER 9
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. Section 1 shall be amended by adding the following definitions:

Eligible Individual – With respect to Tennessee's Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act as amended by Section 2403 of the Affordable Care Act (ACA), the State's approved MFP Operational Protocol and TENNCARE Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Nursing Facility (NF) or an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.

    a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

    b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted *solely* for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

    c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., *not* covered by

Medicare) as a cost-effective alternative (see Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

2. Be eligible for and receive Medicaid benefits for inpatient services furnished by the nursing facility or ICF/MR for at least one (1) day. For purposes of this Agreement, an Eligible Individual must reside in a nursing facility and be enrolled in CHOICES Group 1 for a minimum of one (1) day and must be eligible to enroll and transition seamlessly into CHOICES Group 2 (without delay or interruption).

3. Meet nursing facility or ICF/MR level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility.

Family Member - For purposes of a Qualified Residence under the State's MFP Rebalancing Demonstration, a family member includes a person with any of the following relationships to the member, whether related by blood, marriage, or adoption, and including such relationships (as applicable) that may have been established through longstanding (a year or more) foster care when the member was a minor:

1. Spouse, and parents and siblings thereof;
2. Sons and daughters, and spouses thereof;
3. Parents, and spouses and siblings thereof;
4. Brothers and sisters, and spouses thereof;
5. Grandparents and grandchildren, and spouses thereof; and
6. Domestic partner and parents thereof, including domestic partners of any individual in 2 through 5 of this definition. A domestic partner means an adult in a committed relationship with another adult. Committed relationship means one in which the member, and the domestic partner of the member, are each other's sole domestic partner (and are not married to or domestic partners with anyone else); and share responsibility for a significant measure of each other's common welfare and financial obligations.

Step and in-law relationships are included in this definition, even if the marriage has been dissolved, or a marriage partner is deceased.

Family member may also include the member's legal guardian or conservator or someone who was the legal guardian or conservator of the member when the member was a minor or required a legal guardian or conservator;

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a nursing facility or ICF/MR into a Qualified Residence in the community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

Qualified Institution – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/MR.

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted *solely* for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

Qualified Residence – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(6) of the DRA, the residence in the community in which an Eligible Individual will reside upon transition to the community which shall be one of the following:

1. A home owned or leased by an Eligible Individual or the individual's family member;

2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the Eligible Individual or the individual's family has domain and control; or

3. A residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

Additional requirements pertaining to a Qualified Residence set forth in MFP Policy Guidance issued by the Centers for Medicare and Medicaid Services (CMS) shall apply for all persons participating in MFP.

TENNCARE PreAdmission Evaluation System (TPAES) – A_component of the State's Medicaid Management Information System and part of the system of record for all PreAdmission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTC programs, including CHOICES and the State's MFP Rebalancing Demonstration (MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

Transition Team – Teams the CONTRACTOR may elect to establish in order to fulfill its obligations pursuant to Nursing Facility to Community Transitions (see Section 2.9.6.8) and the MFP Rebalancing Demonstration (see Section 2.9.8). If an MCO elects to use one or more Transition Teams, the Transition Team shall consist of at least one person who meets the qualifications of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator(s) in the performance of transition activities for a CHOICES Group 1 member. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

2. Section 2.9.5.4 shall be amended by adding a new Section 2.9.5.4.1 as follows:

2.9.5.4.1 In addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home will be provided coordination of care by CHOICES and MCO Case Management staff:

2.9.5.4.1.1 Member will be informed by CHOICES care coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;

2.9.5.4.1.2 Member will be referred by CHOICES Care Coordinator to MCO Case Management within three (3) business days of the transition request, for service identification and implementation in the home setting;

2.9.5.4.1.3 MCO Case Manager will be responsible for developing service plan for the home setting;

2.9.5.4.1.4 CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the MCO Case Management staff, the member and/or his parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until the transition plan is complete; and

2.9.5.4.1.5 Any EPSDT benefits needed by the child in the community as an alternative to nursing facility care, including medically necessary home health or private duty nursing, as applicable, shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and EPSDT benefits.

3. Section 2.9.6.3.20.1 shall be deleted and replaced by new Sections 2.9.6.3.20.1 and 2.9.6.3.20.2 and the remaining Sections of 2.9.6.3.20 shall be renumbered accordingly, including any references thereto.

2.9.6.3.20.1 For purposes of the CHOICES program, service authorizations for CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

2.9.6.3.20.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility. If the CONTRACTOR elects to authorize nursing facility services, the CONTRACTOR may determine the duration of time for which nursing facility services will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in

authorizations for CHOICES nursing facility services in accordance with the level of care and/or reimbursement approved by TENNCARE. Retroactive entry or adjustments in service authorizations for nursing facility services should be made only upon notification of retroactive enrollment into or disenrollment from CHOICES Group 1a or 1b via the outbound 834 file from TENNCARE.

4. Section 2.9.6.5.1.1 shall be deleted and replaced as follows:

2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a care coordinator shall conduct any needs assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. This assessment may include identification of targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining functional abilities, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit. The care coordinator shall ensure coordination of the member's physical health, behavioral health, and long-term care needs and shall assess at least annually the member's potential for an interest in transition to the community. For children under the age of 21 in nursing facilities, this shall include explanation to the member or his parent or authorized representative, as applicable, of benefits available pursuant to EPSDT, including medically necessary benefits such as home health or private duty nursing that may be provided in the community as an alternative to nursing facility care.

5. Section 2.9.6.8 shall be amended by adding a new Section 2.9.6.8.2 and the remaining Section 2.9.6.8 shall be renumbered, including any references thereto.

2.9.6.8.2 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are under the age of twenty-one (21) and have requested to transition home will be provided coordination of care by CHOICES and MCO Case Management staff (see Section 2.9.5.4.1).

6. Section 2.9.6.8 shall be amended by adding a new Section 2.9.6.8.16 and renumbering the remaining Sections accordingly including any references thereto.

2.9.6.8.16 Ongoing CHOICES HCBS and any medically necessary covered home health or private duty nursing services needed by the member shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing CHOICES HCBS.

7. Section 2.9.6.9.1.1.1 shall be deleted and replaced as follows:

2.9.6.9.1.1.1 Develop protocols and processes to work with nursing facilities to coordinate the provision of care. At minimum, a care coordinator assigned to a resident of the nursing facility shall participate in quarterly Grand Rounds (as defined in Section 1). At least two of the Grand Rounds per year shall be conducted on-site in the facility, and the Grand Rounds shall identify and address any member who 1) has experienced a potential significant change in needs or circumstances (see Section 2.9.6.9.1.1.5); 2) the nursing facility or MCO has expressed concerns; or 3) is under the age of twenty-one (21).

8. Section 2.9.6.9.4.3.6 shall be amended by adding new text as follows:

2.9.6.9.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are twenty-one years of age and older shall receive a face-to-face visit from their care coordinator at least twice a year with an interval of at least one-hundred and twenty (120) days between visits. Members in CHOICES Group 1 (who are residents of a nursing facility) who are under the age of twenty-one (21) shall receive a face-to-face visit from their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

9. Section 2.9.6.9.4.3 shall be amended by adding a new Section 2.9.6.9.4.3.8 and renumbering the remaining Sections accordingly including any references thereto.

2.9.6.9.4.3.8 Members in CHOICES Group 2 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member's MFP participation period, minimum contacts shall be as described in 2.9.6.9.4.3.7 unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, or based on a significant change in circumstances (see Sections 2.9.6.9.2.1.16. and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

10. The punctuation at the end of Sections 2.9.6.9.6.3.4 and 2.9.6.9.6.3.5 shall be amended as follows:

2.9.6.9.6.3.4 For members in CHOICES Group 2, a completed risk assessment and a risk agreement signed and dated by the member or his/her representative; and

2.9.6.9.6.3.5 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, and a determination by the CONTRACTOR that the projected cost of CHOICES HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap.

11. Section 2.9.6.12.4 shall be deleted and replaced as follows:

2.9.6.12.4 The CONTRACTOR shall require and shall conduct readiness review activities as necessary to confirm that the EVV system vendor has a plan in place and will be compliant with all Version 5010 and ICD-10 coding requirements in a timely manner;

12. Section 2.9.6 shall be amended by adding a new Section 2.9.6.13 as follows:

2.9.6.13 TPAES

2.9.6.13.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES) to facilitate submission of all PreAdmission Evaluation (i.e., level of care) applications, including required documentation pertaining thereto, and to facilitate enrollments into and transitions between LTC programs, including CHOICES. The CONTRACTOR shall comply with all data entry and tracking processes and timelines established by TENNCARE in policy or protocol in order to ensure efficient and effective administration and oversight of the CHOICES program.

13. Section 2.9.7.4.3 shall be amended by adding new Sections 2.9.7.4.3.2 through 2.9.7.4.3.4 as follows:

2.9.7.4.3.2 If a member electing to participate in consumer direction refuses to receive eligible CHOICES HCBS from contract providers while services are initiated through consumer direction, the decision must be documented on a signed and dated Consumer Direction Participation Form. The CONTRACTOR shall not encourage a member to forego receipt of eligible CHOICES HCBS from contract providers while these HCBS are being initiated through consumer direction.

2.9.7.4.3.3 For any CHOICES Group 2 member electing to participate in consumer direction that refuses to receive eligible CHOICES HCBS from contract providers while services are initiated through consumer direction, the member's care coordinator shall visit the member face to face at least monthly to ensure that the member's needs are safely met, and shall continue to offer eligible CHOICES HCBS through contract providers.

2.9.7.4.3.4 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2.

14. Section 2.9.7.4.4 shall be amended as follows:

2.9.7.4.4 Except as specified in 2.9.7.4.3.2. and in accordance with requirements pertaining thereto, the CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, including but not limited to: the

FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

15. Section 2.9 shall be amended by adding a new Section 2.9.8 and renumbering the remaining sections of 2.9 accordingly, including any references thereto.

2.9.8 Money Follows the Person (MFP) Rebalancing Demonstration

2.9.8.1 **General**

2.9.8.1.1 The CONTRACTOR shall, in accordance with this Agreement and federal and State laws, regulations, policies and protocols, assist Eligible Individuals living in a Qualified Institution in transitioning to a Qualified Residence in the community under the State's MFP Rebalancing Demonstration (MFP).

2.9.8.1.2 Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from CHOICES Group 1 into CHOICES Group 2 pursuant to TENNCARE policies and protocols for Nursing Facility-to-community transitions and shall also be enrolled into MFP. For persons enrolled in CHOICES who are also participating in MFP, the CONTRACTOR shall comply with all applicable provisions of this Agreement pertaining to the CHOICES program. This section sets forth additional requirements pertaining to the CONTRACTOR's responsibilities specifically as it relates to MFP.

2.9.8.1.3 For CHOICES Group 1 members not eligible to participate in MFP or who elect not to participate in MFP, the CONTRACTOR shall nonetheless facilitate transition to the community as appropriate and in accordance with 2.9.6.8.

2.9.8.1.4 The CONTRACTOR shall not delay a CHOICES Group 1 member's transition to the community in order to meet the ninety (90)-day minimum stay in a Qualified Institution established under ACA and enroll the person into MFP.

2.9.8.2 Identification of MFP Participants

2.9.8.2.1 The CONTRACTOR shall identify members who may have the ability and/or desire to transition from a nursing facility to the community in accordance with Section 2.9.6.8.

2.9.8.2.2 The CONTRACTOR shall assess all nursing facility residents transitioning from the NF to CHOICES Group 2 for participation in MFP. This includes CHOICES Group 1 members referred for transition, as well as nursing facility residents referred for CHOICES who are not yet enrolled in CHOICES Group 1 but may be determined eligible for Group 1, and who have expressed a desire to move back into the community. However, the resident must actually be enrolled into Group 1 in order to qualify for MFP.

2.9.8.2.3 Members may only elect to participate in MFP and the CONTRACTOR may only enroll a member into MFP prior to the member's transition from the nursing facility to the community. Members will not be eligible to enroll in MFP if they have already transitioned out of the nursing facility.

2.9.8.3. Eligibility/Enrollment into MFP

2.9.8.3.1 Member participation in MFP is voluntary. Members may deny consent to participate in MFP or may withdraw consent to participate in MFP at any time without affecting their enrollment in CHOICES.

2.9.8.3.2 If a member withdraws from MFP, he cannot participate in MFP again without meeting the eligibility requirements for enrollment into MFP (e.g., following a ninety (90)-day stay in a Qualified Institution).

2.9.8.3.3 Only CHOICES Group 1 members who qualify to enroll in CHOICES Group 2 shall be eligible to transition to Group 2 and enroll into MFP.

2.9.8.3.4 In addition to facilitating transition from CHOICES Group 1 to CHOICES Group 2 pursuant to Section 2.9.6.8 of this Agreement and TENNCARE's policies and protocols, the CONTRACTOR shall facilitate the enrollment of Eligible Individuals who consent into MFP.

2.9.8.3.5 The member's care coordinator or, if the CONTRACTOR elects to use transition teams, a person who meets the qualifications of a care coordinator shall, using information provided by TENNCARE, provide each potential MFP participant with an overview of MFP and answer any questions the participant has. The CONTRACTOR shall have each potential MFP participant or his authorized representative, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by the CONTRACTOR and documenting the member's decision regarding MFP participation.

2.9.8.3.6 Once a potential MFP participant has consented to participate in MFP, the CONTRACTOR shall notify TENNCARE within two (2) business days via the Tennessee PreAdmission Evaluation System (TPAES) unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.3.7 The CONTRACTOR shall verify that each potential MFP participant is an Eligible Individual and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.3.8 The CONTRACTOR shall verify that each potential MFP participant will transition into a Qualified Residence in the community and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.3.9 Final determinations regarding whether a member can enroll into MFP shall be made by TENNCARE based on information provided by the CONTRACTOR.

2.9.8.3.10 TENNCARE may request and the CONTRACTOR shall submit in a timely manner additional documentation as needed to make such determination. Documentation submitted by the CONTRACTOR may be verified, to the extent practicable, by other information, either prior or subsequent to enrollment in MFP, including eligibility, claims and encounter data.

2.9.8.4 Participation in MFP

2.9.8.4.1 The participation period for MFP is 365 days. This includes all days during which the member resides in the community, regardless of whether CHOICES HCBS are received each day. Days are counted consecutively except for days during which the member is admitted to an inpatient facility.

2.9.8.4.2 The participation period for MFP does not include any days during which the member is admitted to an inpatient facility.

2.9.8.4.3 MFP participation will be "suspended" in the event a member is re-admitted for a short-term inpatient facility stay. Member will not have to re-qualify for MFP regardless of the number of days the member is in the inpatient facility, and shall be re-instated in MFP upon return to a Qualified Residence in the community.

2.9.8.4.4 It may take longer than 365 calendar days to complete the 365-day MFP participation period days since a member's participation period may be interrupted by one or more inpatient facility stays.

2.9.8.4.5 For MFP participants, a significant change in circumstances (see 2.9.6.9.2.1.16.) shall include any admission to an inpatient facility, including a hospital, psychiatric hospital, PRTF, nursing facility or Medicare-certified Skilled Nursing Facility. The member's Care Coordinator shall (pursuant to 2.9.6.2.4) visit the member face-to-face within five (5) business days of any inpatient facility admission and shall assess the member's needs, conduct a comprehensive needs assessment and update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances. If the visit is conducted in the inpatient facility, the CONTRACTOR may elect to have someone who meets the qualifications of a Care Coordinator complete the required face-to-face visit and conduct a comprehensive needs assessment, in which case, the qualified individual conducting the face-to-face visit shall coordinate with the member's Care Coordinator to update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.

2.9.8.4.6 The CONTRACTOR shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that continued participation in CHOICES Group 2 and in MFP is appropriate.

2.9.8.4.7 The CONTRACTOR shall notify TENNCARE within five (5) business days of admission any time a member is admitted to an inpatient facility. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.4.7.1. For purposes of MFP, admission for observation (which is not considered inpatient care) shall not be considered admission to an inpatient facility. Nor shall participation in MFP be suspended during observation days.

2.9.8.4.8 The CONTRACTOR shall be involved in discharge planning on behalf of any MFP participant admitted to an inpatient facility.

2.9.8.4.9 The CONTRACTOR shall notify TENNCARE within two (2) business days when an MFP participant is discharged from a short-term stay in an inpatient facility. Such notification shall include whether the member is returning to the same Qualified Residence in which he lived prior to the inpatient stay, or a different residence which shall also be a Qualified Residence. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.4.10 If at any time during the member's participation in MFP, the member changes residences, including instances in which the change in residences occurs upon discharge from an inpatient facility stay, the CONTRACTOR shall: 1) notify TENNCARE within two (2) business days of the change in residence; 2) verify that the new residence is a Qualified Residence; and 3) provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

2.9.8.4.11 The CONTRACTOR shall track the member's residency throughout the 365-day MFP participation period. In addition, the CONTRACTOR shall, for purposes of facilitating completion of Quality of Life surveys, continue to track MFP participants' residency for two (2) years following transition to the community which may be up to one (1) year following completion of the MFP participation period, or until the member is no longer enrolled in the CONTRACTOR's health plan.

2.9.8.4.12 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice of MFP participation to each member enrolled in MFP which shall not occur prior to transition from CHOICES Group 1 to CHOICES Group 2. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is enrolled in MFP.

2.9.8.4.13 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice to each member upon conclusion of the 365-day participation period. Such notice shall be issued within ten (10) business days of notification from

TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is no longer enrolled in MFP.

2.9.8.4.14 A member who successfully completes 365-day participation period for MFP and is subsequently re-institutionalized may qualify to participate in MFP again but must first meet the "Eligible Individual" criteria. There shall be a minimum of ninety (90) days between MFP participation occurrences. Prior to enrollment in a second MFP occurrence, the care coordinator shall assess the reason for the re-institutionalization to determine if the member is an appropriate candidate for re-enrollment in MFP and if so, shall develop a plan of care (including a Risk Agreement) that will help to ensure that appropriate supports and services are in place to support successful transition and permanency in the community.

2.9.8.5 Plan of Care

2.9.8.5.1 For members participating in the MFP, the Plan of Care shall reflect that the member is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from CHOICES Group 1 to CHOICES Group 2).

2.9.8.5.2 Upon conclusion of the member's 365-day participation period in MFP, the Plan of Care shall be updated to reflect that he is longer participating in MFP.

2.9.8.6 Services

2.9.8.6.1 A member enrolled in MFP shall be simultaneously enrolled in CHOICES Group 2 and shall be eligible to receive covered benefits as described in 2.6.1.

2.9.8.7 Continuity of Care

2.9.8.7.1 Upon completion of a person's 365-day participation in MFP, services (including CHOICES HCBS) shall continue to be provided in accordance with the covered benefits described in 2.6.1 and the member's plan of care. Transition from participation in MFP and CHOICES Group 2 to participation only in CHOICES Group 2 shall be seamless to the member, except that the CONTRACTOR shall be required to issue notice of the member's conclusion of his 365-day MFP participation period.

2.9.8.8 Short-Term Nursing Facility Stay

2.9.8.8.1 A CHOICES Group 2 member may be admitted for an inpatient short-term nursing facility stay for up to ninety (90) days and remain enrolled in CHOICES Group 2 (see Section 2.6.1.5.4). The CONTRACTOR shall ensure that the member is transitioned from Group 2 to Group 1 at any time: a) it is determined that the stay will not be short-term and the member will not transition back to the community; and b) prior to exhausting the ninety (90) day short-term nursing facility benefit covered for CHOICES Group 2 members (see Section 2.9.6.8.23.4).

2.9.8.8.2 A CHOICES Group 2 member participating in MFP may be admitted for an inpatient short-term nursing facility stay during his 365-day participation period and remain enrolled in MFP regardless of the number of days the member is admitted for inpatient facility care.

2.9.8.8.3 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.

2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 to CHOICES Group 1.

2.9.8.8.5 The member's care coordinator shall monitor the member's inpatient stay and shall visit the member face-to-face at least monthly during the inpatient stay or more frequently as necessary to facilitate timely and appropriate discharge planning.

2.9.8.8.6 The CONTRACTOR shall conduct a Transition Assessment and develop a Transition Plan (see Section 2.9.6.8) as necessary to facilitate the member's return to the community. Such assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 and continued participation in MFP is appropriate. The CONTRACTOR shall update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.

2.9.8.8.7 Upon discharge from the short-term stay, within one (1) business day, the care coordinator shall visit the member in his/her Qualified Residence. During the ninety (90) days following transition and re-instatement into MFP, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community.

2.9.8.8.8 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.

2.9.8.8.9 Days that are spent in an inpatient facility, including short-term nursing facility stays, do not count as part of the member's 365-day MFP participation period.

2.9.8.9 <u>TPAES</u>

2.9.8.9.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES) to facilitate enrollments into and transitions between LTC programs, including CHOICES and the State's MFP Rebalancing Demonstration (MFP), and shall comply with all data collection processes and timelines established by TENNCARE in policy or protocol in order to gather data required to comply with tracking and reporting requirements pertaining to MFP. This shall include (but is not

limited to) attestations pertaining to Eligible Individual and Qualified Residence, changes of residence, inpatient facility admissions and discharges, reasons for re-institutionalization, and reasons for disenrollment from MFP.

2.9.8.10 IT requirements

2.9.8.10.1 Pursuant to Section 2.23 of this Agreement, the CONTRACTOR shall modify its information systems to accommodate, accept, load, utilize and facilitate accurate and timely reporting on information submitted to by TENNCARE via the outbound 834 file that will identify MFP participants, as well as those MFP participants in suspended status during an inpatient admission.

2.9.8.11 Case Management System

2.9.8.11.1 The CONTRACTOR's case management system (see Section 2.9.6.12.6) shall identify persons enrolled in MFP and shall generate reports and management tools as needed to facilitate and monitor compliance with contract requirements and timelines.

2.9.8.12 MFP Readiness Review

2.9.8.12.1 Prior to implementation of MFP, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that the CONTRACTOR is able to meet all of the requirements pertaining to MFP set forth in this Agreement.

2.9.8.12.2 The CONTRACTOR shall cooperate in a "readiness review" conducted by TENNCARE to review the CONTRACTOR's readiness to fulfill its obligations regarding MFP in accordance with the Agreement. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all MFP requirements of the Agreement as determined by TENNCARE.

2.9.8.12.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

2.9.8.13 MFP Benchmarks

2.9.8.13.1 The CONTRACTOR shall assist TENNCARE in meeting the five (5) annual benchmarks established for the MFP Rebalancing Demonstration which are described below in Sections 2.9.8.13.1.1 through 2.9.8.13.1.5.

2.9.8.13.1.1 *Benchmark # 1: Number of Persons Transitioned*

2.9.8.13.1.1.1 Assist the projected number of eligible individuals in each target group in successfully transitioning from an inpatient facility to a qualified residence during each year of the demonstration. Projected numbers:

Calendar Year	# of Elderly Transitioned	# of Disabled Adults Transitioned
2011	27	23
2012	206	169
2013	261	214
2014	261	214
2015	234	191
2016	206	169

2.9.8.13.1.1.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #1 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 1. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

2.9.8.13.1.2 *Benchmark #2: Qualified Expenditures for HCBS*

2.9.8.13.1.2.1 Increase the amount and percentage of Medicaid spending for qualified home and community based long-term care services during each year of the demonstration.

2.9.8.13.1.2.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.3 *Benchmark #3: Increased Amount and Percentage of HCBS Participants*

2.9.8.13.1.3.1 Increase the number and percentage of individuals who are elderly and adults with physical disabilities receiving Medicaid-reimbursed long-term care services in home and community based (versus institutional) settings during each year of the demonstration.

2.9.8.13.1.3.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

2.9.8.13.1.4 *Benchmark #4: Increase Unduplicated Contracted Community Based Residential Alternative*

2.9.8.13.1.4.1 Increase the number of unduplicated licensed CBRAs contracted with MCOs Statewide to provide HCBS in the CHOICES program during each year of the demonstration. Providers enrolled with more than one (MCO) or in more than one region shall only be counted once. Proposed numbers:

Calendar Year	# of MCO Contracted CBRAs Statewide
2011	70
2012	74
2013	78
2014	82
2015	86
2016	90

2.9.8.13.1.4. 2 For purposes of incentive payments (See Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.5 Benchmark #5: Increase Participation in Consumer Direction

2.9.8.13.1.5.1 Increase the number of persons receiving Medicaid-reimbursed HCBS participating in consumer direction for some or all services during each year of the demonstration. Projected numbers:

Calendar Year	# in Consumer Direction
2011	450
2012	750
2013	1,000
2014	1,250
2015	1,400
2016	1,500

2.9.8.13.1.5.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #5 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 2. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

16. Section 2.18.6.5 shall be deleted and replaced as follows:

2.18.6.5 The CONTRACTOR shall develop and implement a training plan to educate long-term care providers regarding compliance with all Version 5010 and ICD-10 coding requirements;

17. Section 2.21.4.1.4 shall be amended by deleting obsolete references and shall read as follows:

2.21.4.1.4 The claims specified in Section 2.21.4.1.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

18. The introductory paragraph of Section 2.30.6.4 shall be deleted and replaced as follows:

2.30.6.4 The CONTRACTOR shall submit a quarterly *CHOICES Nursing Facility to Community Transition Report*. MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall include information, by month, on specified measures, which shall include but not be limited to the following:

19. The introductory paragraph of Section 2.30.6.6 shall be deleted and replaced as follows:

2.30.6.6 The CONTRACTOR shall submit a quarterly *CHOICES Consumer Direction of HCBS Report*. MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:

20. Section 2.30.6.6 shall be amended by adding a new Item (9) as follows:

(9) The total number and the name, SSN, and phone number, and the authorized representative name and phone number, if applicable, of each member referred to the FEA (for enrollment into consumer direction) that has indicated on his Consumer Direction Participation Form that he does not wish to receive HCBS from contract providers pending enrollment into consumer direction, including the member's date of enrollment in CHOICES Group 2, the date of referral to the FEA for consumer direction, and the total number of days that HCBS have not been received by each member.

21. Section 2.30.6 shall be amended by adding a new Section 2.30.6.8 and renumbering the remaining Sections accordingly, including any references thereto.

2.30.6.8 The CONTRACTOR shall submit a quarterly *MFP Participants Report*. The report shall include information on specified measures, which shall include but not be limited to the following:

(1) The total number and the name and SSN of each CHOICES Group 2 member enrolled into MFP;

(2) The date of each member's transition to the community (or for persons enrolled in MFP upon enrollment to the CONTRACTOR's health plan, the date of enrollment into the CONTRACTOR's health plan);

(3) Each member's current place of residence including physical address and type of Qualified Residence;

(4) The date of the last care coordination visit to each member;

(5) Any inpatient facility stays during the quarter, including the member's name and SSN type of Qualified Institution, dates of admission and discharge, and the reason for admission; and

(6) The total number and name and SSN of each member disenrolled from MFP during the quarter, including the reason for disenrollment.

The CONTRACTOR shall submit its first report following the end of calendar year 2011.

22. 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.* MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. 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.

23. Section 2.30.10.6 shall be deleted in its entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

24. The introductory paragraph of Section 2.30.11.6 shall be deleted and replaced as follows:

2.30.11.6 The CONTRACTOR shall submit a quarterly *CHOICES HCBS Critical Incidents Report* (see Section 2.15.7). MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall provide information, by month regarding specified measures, which shall include but not be limited to the following:

25. The introductory paragraph of Section 2.30.16.4 shall be deleted and replaced as follows:

2.30.16.4 The CONTRACTOR shall submit a quarterly *CHOICES Cost Effective Alternatives Report* that provides information on cost effective alternative services provided to

CHOICES members (see Section 2.6.5.2). MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall provide information regarding specified measures, including but not limited to the following:

26. Section 3.3.1 shall be amended by adding a new Section 3.3.1.1 as follows:

3.3.1.1 The capitation payment for MFP participants who must also be enrolled in CHOICES will be the applicable CHOICES capitation payment. There will be no add-on for MFP participants.

27. Section 3 shall be amended by adding a new Section 3.11 and renumbering the remaining Section 3 accordingly, including any references thereto.

3.11 MFP INCENTIVE PAYMENTS

3.11.1 Financial incentives will be paid to the CONTRACTOR based on activities performed as part of the MFP Rebalancing Demonstration and in accordance with the following:

3.11.1.1 Upon successful transition to the community of each MFP demonstration participant up to and including the MCO's established benchmark for the calendar year – a one-time payment of $1,000.

3.11.1.1.1 If a member has been enrolled in more than one MCO during the ninety (90)-day minimum stay in a Qualified Institution established under ADA, the incentive payment shall be awarded to the MCO in which the person is enrolled at transition to the community and enrollment into MFP.

3.11.1.2 Upon successful transition to the community of each MFP demonstration participant that exceeds the MCO's established benchmark for the calendar year – a one-time payment of $2,000.

3.11.1.2.1 If a member has been enrolled in more than one MCO during the ninety (90)-day minimum stay in a Qualified Institution established under ADA, the incentive payment shall be awarded to the MCO in which the person is enrolled at transition to the community and enrollment into MFP.

3.11.1.3 Upon each MFP demonstration participant's completion of community living for the full 365-day demonstration participation period without readmission to a nursing facility (excluding short-term SNF stays *solely* for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare), a one-time payment of $5,000.

3.11.1.3.1 If a member has been enrolled in more than one MCO during the 365-day participation period in MFP, a pro-rated portion of the incentive payment shall be awarded to each MCO based on the number of days the member was enrolled in each plan. Only days included in the 365-day participation period shall be counted and not any days during which MFP participation was suspended during an inpatient facility stay.

3.11.1.4 Upon achievement of only one (1) of the remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (including partial year 2011), a one-time payment of $10,000 per MCO.

3.11.1.5 Upon achievement of only two (2) remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (including partial year 2011), a one-time payment of $25,000 per MCO.

3.11.1.6 Upon achievement of only three (3) remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (including partial year 2011), a one-time payment of $50,000 per MCO.

3.11.1.7 Upon achievement of all four (4) of the remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (including partial year 2011), a one-time payment of $100,000 per MCO.

3.11.2 The CONTRACTOR shall be eligible to receive only one incentive payment pertaining to benchmarks #s 2-5 which shall depend on the total number of benchmarks which the CONTRACTOR meets or exceeds. These incentive payments are not cumulative.

3.11.3 MFP incentive payments pertaining to benchmark #1 shall be payable within thirty (30) days following the end of each calendar quarter for activities performed during the quarter.

3.11.4 The MFP incentive payments pertaining to benchmark #s 3-5 (which shall depend on the total number of these benchmarks which the CONTRACTOR meets or exceeds) shall be payable within thirty (30) days following the end of each calendar year for activities performed during the year.

3.11.5 Any additional MFP incentive payment pertaining to achievement of benchmark #2, which shall reflect the difference between the total incentive payment due the CONTRACTOR for benchmarks #s 2-5 and the incentive payment already made in Section 3.11.4 above (see Section 3.11.2), shall be due by June 30 following the close of the calendar year to permit adequate time for any lag in claims and encounter submission.

28. The liquidated damage chart in Section 4.20.2.2.7 shall be amended by adding new damages A.27 through A.30 as follows:

A.27	Failure to process a transition referral, including completion of a face-to-face transition screening and assessment and development of a transition plan timely and in accordance with 2.9.6.8 and TENNCARE policy and protocols	$500 per occurrence
A.28	Failure to initiate CHOICES HCBS or for children under age 21, EPSDT benefits provided as an alternative to nursing facility care in accordance with the member's plan of care and to ensure that such HCBS or EPSDT benefits are in place immediately upon transition from a nursing facility to the community for any person transitioning from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2), including persons enrolled in MFP (see Sections 2.9.5.4.1.5 and 2.9.6.8.16)	$500 per day for each day that HCBS are not in place following transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) in addition to the cost of services not provided
A.29	Failure to complete in a timely manner minimum care coordination contacts required for persons transitioned from a nursing facility to CHOICES Group 2, including post-discharge and following a significant change in circumstances (see Sections 2.9.6 and 2.9.8)	$500 per occurrence

A.30	Failure to submit complete and accurate data into TPAES pertaining to MFP, or to comply with all data collection processes and timelines established by TENNCARE in policy or protocol in order to gather data required to comply with tracking and reporting requirements pertaining to MFP. This shall include (but is not limited to) attestations pertaining to Eligible Individual and Qualified Residence, changes of residence, inpatient facility admissions and discharges, reasons for re-institutionalization, and reasons for disenrollment from MFP.		$500 per occurrence

29. Attachment I shall be deleted and replaced in its entirety as follows:

ATTACHMENT I

BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance abuse issues. Recovery is a consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life [with] a disability.

SERVICE	**Mental Health Case Management**

DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based,

with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals: 1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

1) All mental health case managers shall have, at a minimum, a bachelor's degree or be licensed as a Registered Nurse;
2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
4) Fifty-one percent (51%) of all mental health case management services should take place outside the case manager's office;
5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the ACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) No arbitrary time limit on receiving services;
8) Individualized treatment, support and rehabilitation services;
9) Twenty-four (24) hour a day availability of services; and
10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the "imminent" risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation

DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members and are Certified Peer Support Specialists. A Certified Peer Support Specialist is a person who has identified himself or herself as having received or is receiving mental health or co-occurring disorder services in his or her personal recovery process and has undergone training recognized by the Tennessee Department of Mental Health, Office of Consumer Affairs on how to assist peers with the recovery process.

These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum, but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

SERVICE	**Crisis Services**

Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Peer support specialists shall be utilized in conjunction with

crisis specialists to assist adults in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center
- If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis
- For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.

Amendment 9 (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 October 1, 2011.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A Emkes /cs
Mark Emkes
Commissioner

DATE: 9/20/11

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

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

DATE: 9/6/11

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A Emkes /cs
Mark Emkes
Commissioner

DATE: 9/27/11

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: Justin P. Wilson
Justin P. Wilson
Comptroller

DATE: 10/10/11

CONTRACT SUMMARY SHEET

021406

CONTRACT NOT PAID THROUGH EDISON

RFS #	Contract #
318.66-051	FA-07-16937-08
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	December 31, 2014	Subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
2012	$ 334,025,134.00	$ 655,180,701.00			$ 989,205,835.00
TOTAL:	$ 1,391,950,970.00	$ 2,943,204,571.00	$ -	$ -	**$ 4,335,155,541.00**

OGR RELEASED JUN 08 2011 AGENCY TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
2012		$ 989,205,835.00
TOTAL:	$ 3,345,949,706.00	$ 989,205,835.00
End Date	June 30, 2011	December 31, 2014

State Agency Fiscal Contact & Telephone #

Scott Pierce 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)

Mark A Emkes per MOM

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

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg,ID,GG,GU) [ ] Other

OGR JUN 03 2011 RECEIVED

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

AMENDMENT NUMBER 8
MIDDLE 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-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

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

Back-up Plan – A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or non-residential CHOICES HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services with assistance from the FEA as needed.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Agreement and in accordance with Section 2.9.6., but shall not perform activities that must be performed by the Care Coordinator, including needs assessment, development of the plan of care, and minimum Care Coordination contacts.

Caregiver – For purposes of CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or for consumer direction of eligible CHOICES HCBS.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
   Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

2. Group 2
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

3. Group 3
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are "at-risk" for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations. Group 3 was not included in CHOICES on the date of CHOICES implementation. TENNCARE intends to include CHOICES Group 3 at such time that the State is permitted to modify nursing facility level of care based on CMS interpretation of maintenance of effort requirements set forth in the Affordable Care Act. . TENNCARE will notify the CONTRACTOR at least sixty (60) days prior to the proposed date for including Group 3 in CHOICES. As of the date specified in that notice, the CONTRACTOR shall accept members in CHOICES Group 3 and shall implement all of the requirements in this Agreement that are applicable to CHOICES Group 3.

Consumer – Except when used regarding consumer direction of eligible CHOICES HCBS, an individual who uses a mental health or substance abuse service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES member participating in consumer direction of eligible CHOICES HCBS or his/her representative to provide one or more eligible CHOICES HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of Eligible CHOICES HCBS – The opportunity for a CHOICES member assessed to need specified types of CHOICES HCBS including attendant care, personal care, homemaker, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as

determined in accordance with TennCare policy. A member's individual cost neutrality cap shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TennCare based on information submitted by the AAAD or MCO (as applicable) in the PAE application.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

Electronic Visit Verification (EVV) System – An electronic system into which provider staff and consumer-directed workers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of specified CHOICES HCBS and which may also be utilized for submission of claims.

Eligible CHOICES HCBS – Attendant care, personal care, homemaker, in-home respite, companion care services and/or any other CHOICES HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Employer of Record – The member participating in consumer direction of eligible CHOICES HCBS or a representative designated by the member to assume the consumer direction of eligible CHOICES HCBS functions on the member's behalf.

Expenditure Cap – The annual limit on expenditures for CHOICES HCBS, excluding home modifications, for CHOICES members in CHOICES Group 3. The expenditure cap is $15,000.

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps CHOICES members participating in consumer direction of eligible CHOICES HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES members participating in consumer direction of eligible CHOICES HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible CHOICES HCBS authorized and provided.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

Immediate Eligibility – A mechanism by which the State can, based on a preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of CHOICES HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered ongoing CHOICES HCBS, be determined by TENNCARE to meet nursing facility level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES Group 2 based on review of the financial information provided by the applicant. Immediate eligibility shall only be for specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days from the effective date of eligibility.

One-Time CHOICES HCBS – Specified CHOICES HCBS which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time HCBS include in-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

Ongoing CHOICES HCBS – Specified CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of community-based residential alternatives and PERS) on a continuous basis. Ongoing HCBS include community-based residential alternatives, personal care, attendant care, homemaker services, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

Representative – In general, for CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care planning and implementation and to speak and make decisions on the member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns. As it relates to consumer direction of eligible CHOICES HCBS, a person who is authorized by the member to direct and manage the member's worker(s), and signs a representative agreement. The representative for consumer direction of eligible CHOICES HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand his/her support needs; know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

Representative Agreement – The agreement between a CHOICES member electing consumer direction of eligible CHOICES HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

Risk Agreement – An agreement signed by a member who will receive CHOICES HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the possible consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member's decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.

Self-Direction of Health Care Tasks – A decision by a CHOICES member participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES HCBS in

the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible CHOICES HCBS s/he is authorized to receive.

Service Agreement – The agreement between a CHOICES member electing consumer direction of eligible CHOICES HCBS (or the member's representative) and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing CHOICES HCBS that was not initiated by a member, including late and missed visits.

Supports Broker – An individual assigned by the FEA to each CHOICES member participating in consumer direction who assists the member/representative in performing the employer of record functions, including, but not limited to: developing job descriptions; locating; recruiting; interviewing; scheduling; monitoring; and evaluating workers. The supports broker collaborates with, but does not duplicate, the functions of the member's care coordinator. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.

2. Section 1 shall be amended by adding the following definition:

CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

3. Sections 2.4.5.1 and 2.4.5.2 shall be amended by adding the words "outbound 834" in front of the words "enrollment file".

4. Section 2.4.6.1 shall be amended by adding the words "outbound 834" in front of the words "enrollment files".

5. Section 2.4.6.2 shall be amended by adding the words "(inbound 834)" after the words "eligibility file".

6. The first sentence of the third paragraph in the Benefit Limit description for "Non-Emergency Medical Transportation (Including Non-Emergency Ambulance Transportation)" of Section 2.6.1.3 shall be amended by deleting the phrase ", including services".

"The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program."

7. Sections 2.6.1.5 through 2.6.1.5.8.5 shall be deleted and replaced as follows:

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1).

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care including for Group 2, that the enrollee needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee's combined CHOICES HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR's request to provide CHOICES HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 For persons determined to be eligible for enrollment in Group 2 as a result of Immediate Eligibility (as defined in Section 1 of this Agreement), the CONTRACTOR shall provide a limited package of CHOICES HCBS (personal care, attendant care, homemaker services, home-delivered meals, PERS, adult day care, and/or any other services as specified in

TennCare rules and regulations) as identified through a needs assessment and specified in the plan of care. Upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, the CONTRACTOR shall authorize additional services in accordance with Section 2.9.6.2.5. For members residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.6.1.5.4 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day)		X	X
Attendant care (up to 1080 hours per calendar year)		X	X
Homemaker services (up to 3 visits per week)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

2.6.1.5.5 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section 1 of this Agreement) for CHOICES Group 2 or the expenditure cap for Group 3.

2.6.1.5.5.1 For CHOICES members in Group 2, the services that shall be compared against the member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

2.6.1.5.5.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section 1 of this Agreement).

2.6.1.5.6 CHOICES members may, pursuant to Section 2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.

2.6.1.5.7 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are not receiving long-term care services. Pursuant to Section 2.30.10.5, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the *CHOICES Utilization Report*. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.

2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.5.8.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

2.6.1.5.8.2 A member in Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into his/her place of residence (Section 2.9.6);

2.6.1.5.8.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's plan of care; and

2.6.1.5.8.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section 2.6.7.2).

2.6.1.5.8.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Bureau of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.5.8.6 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TennCare.

2.6.1.5.9 The CONTRACTOR may submit to TENNCARE a request to disenroll from CHOICES a member who is not receiving any Medicaid-reimbursed LTC services based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.5.9.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management notes; and phone numbers that may be provided in TENNCARE's TPAES system. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTC providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.5.9.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.5.9.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

8. Sections 2.6.5.2.1 through 2.6.5.2.3 shall be amended by inserting the word "CHOICES" before the word "HCBS".

9. Section 2.6.5.3 shall be deleted and replaced as follows:

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

10. Sections 2.6.7.2 through 2.6.7.2.5 shall be deleted and replaced as follows:

2.6.7.2 Patient Liability

2.6.7.2.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for CHOICES members via the outbound 834 enrollment file.

2.6.7.2.1.1 When TENNCARE notifies the CONTRACTOR of patient liability amounts for CHOICES members via the outbound 834 enrollment file with an effective date any time other than the first day of the month, the CONTRACTOR shall determine and apply the pro-rated portion of patient liability for that month.

2.6.7.2.2 The CONTRACTOR shall delegate collection of patient liability for CHOICES Group 1 members to the nursing facility and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.2.1 In accordance with the involuntary discharge process, including notice and appeal (see Section 2.12.11.3), a nursing facility may refuse to continue providing services to a member who fails to pay his or her patient liability and for whom the nursing facility can demonstrate to the CONTRACTOR that it has made a good faith effort to collect payment.

2.6.7.2.2.2 If the CONTRACTOR is notified that a nursing facility is considering discharging a member (see Section 2.12.11.3), the CONTRACTOR shall work to find an alternate nursing facility willing to serve the member and document its efforts in the member's files.

2.6.7.2.2.3 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the member otherwise qualifies to enroll in CHOICES Group 2, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, and the CONTRACTOR is willing to continue serving a member who has failed to pay his or her patient liability or if TENNCARE determines that the member would not have patient liability in the community setting, the member shall be offered a choice of CHOICES HCBS. If the member chooses CHOICES HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding transition to Group 2 (Section 2.9.6.3).

2.6.7.2.2.4 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the CONTRACTOR determines that it cannot safely and effectively serve the member in the community and within the cost neutrality cap, the member declines to enroll in Group 2, or TENNCARE determines that the member would continue to have patient liability in the community setting and the CONTRACTOR is unwilling to continue serving the member who has failed to pay his or her patient liability, or TENNCARE denies enrollment in Group 2, the CONTRACTOR may, pursuant to Section 2.6.1.5.8, request to no longer provide long-term care services to the member.

2.6.7.2.3 For CHOICES Group 2 and 3 members, patient liability shall be collected as follows:

2.6.7.2.3.1 The CONTRACTOR shall delegate collection of patient liability for CHOICES Group 2 members who reside in a CBRA facility to the CBRA facility and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.3.2 The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 members (as applicable) who receive CHOICES HCBS in his/her own home and from Group 2 members who receive Companion Care.

2.6.7.2.3.2.1 The CONTRACTOR shall use calculated patient liability amounts to offset the cost of CHOICES Group 2 benefits (or CEA services provided as an alternative to covered CHOICES Group 2 benefits) reimbursed by the CONTRACTOR for that month.

2.6.7.2.3.2.2 The CONTRACTOR shall not collect patient liability that exceeds the cost of CHOICES Group 2 benefits (or CEA services provided as an alternative to CHOICES Group 2 benefits) reimbursed by the CONTRACTOR for that month.

2.6.7.2.3.2.3 The CONTRACTOR shall, upon notification in the outbound 834 enrollment file of retroactive adjustments in patient liability amounts based on Item D deductions, without requiring any action on the part of the member or provider, adjust the Group 2 or Group 3 member's patient liability for the following month(s) until reimbursement of any overpayment is accomplished, or shall refund any overpayments within thirty (30) days of a request from the member or when the member will not continue to have patient liability obligations going forward.

2.6.7.2.3.3 If a Group 2 member fails to pay required patient liability, pursuant to Section 2.6.1.5.8.5, the CONTRACTOR may request to no longer provide long-term care services to the member.

2.6.7.2.3.4 The CONTRACTOR shall not waive or otherwise fail to establish and maintain processes for collection of patient liability in accordance with this Agreement.

11. Section 2.7.2.1.2 shall be deleted and replaced as follows:

2.7.2.1.2 The CONTRACTOR shall provide behavioral health services in accordance with this Agreement, TennCare Rules and Regulations and TennCare policies, including Section 2.6 and Attachment I of this Agreement, and TennCare Medical Necessity Rule 1200-13-16.

12. Section 2.7.3 shall be deleted and replaced as follows:

2.7.3 **Self-Direction of Health Care Tasks**

The CONTRACTOR shall, in accordance with TennCare rules and regulations, permit CHOICES members the option to direct and supervise a consumer-directed worker who is providing eligible CHOICES HCBS in the performance of health care tasks.

13. Section 2.8.1.2 shall be amended by adding the phrase "and updated as described in current NCQA Standards" as follows:

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 and updated as described in current NCQA Standards 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.

14. Section 2.8.1.6 shall be deleted and replaced as follows:

2.8.1.6 As part of its DM program descriptions, the CONTRACTOR shall also describe how the organization integrates member information and coordinates with and has timely access to MCO case management activities and other supporting entities, including but not limited to, Utilization Management (UM), CHOICES, Health Information Lines and Wellness programs, to assure programs are linked and enrollees receive appropriate and timely care.

15. Section 2.8.7.2 shall be amended by deleting the word "passive".

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

16. Sections 2.9.2.1.4 through 2.9.2.1.4.6.5 shall be deleted and replaced as follows:

2.9.2.1.4 For covered long-term care services for CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both CHOICES HCBS authorized by the transferring MCO and nursing facility services, without regard to whether such services are being provided by contract or non-contract providers.

2.9.2.1.4.1 For a member in CHOICES Group 2 or 3, the CONTRACTOR shall continue CHOICES HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce these services unless a care coordinator has conducted a comprehensive needs assessment and developed a plan of care, and the CONTRACTOR has authorized and initiated CHOICES HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 or 3 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility

services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

2.9.2.1.4.2 For a member in CHOICES Group 2 or 3, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If a member in Group 2 or 3 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate prior to the member's exhaustion of the 90-day short-term NF benefit.

2.9.2.1.4.3 If at any time before conducting a comprehensive needs assessment for a member in CHOICES Group 2 or 3 the CONTRACTOR becomes aware of an increase in the member's needs, a care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs.

2.9.2.1.4.4 For a member in CHOICES Group 1, a care coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5).

2.9.2.1.4.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.

2.9.2.1.4.6 The CONTRACTOR shall not:

2.9.2.1.4.6.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR

or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

2.9.2.1.4.6.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1;

2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1; or

2.9.2.1.4.6.5 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

17. Sections 2.9.2.1.5 through 2.9.2.1.5.6.4 shall be deleted in their entirety including any references thereto.

18. Section 2.9.2.5 shall be deleted and replaced as follows:

2.9.2.5 If the CONTRACTOR becomes aware that a CHOICES member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the member's care coordinator or care coordination team) shall, in accordance with protocols established by TENNCARE, work with the other MCO in facilitating a seamless transition for that member.

19. Section 2.9.3.3, 2.9.3.4 and 2.9.3.6 shall be deleted and replaced as follows:

2.9.3.3 For members in Group 2 the CONTRACTOR shall continue HCBS in the member's approved HCBS E/D waiver plan of care except case management for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce HCBS unless the member's care coordinator has conducted a comprehensive needs assessment and developed a plan of care and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12).

2.9.3.4 For a member in CHOICES Group 2, within ninety (90) days of CHOICES implementation, the member's care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS in accordance with the new plan of care. If a member in Group 2 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR the member's care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing services approved by TENNCARE, but no more than ninety (90) days after CHOICES implementation, to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to ninety (90) days after CHOICES implementation, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.

2.9.3.6 The CONTRACTOR shall provide nursing facility services to a member in Group 1 in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

20. Section 2.9.3.9.2 and 2.9.3.9.4 shall be deleted and replaced as follows:

2.9.3.9.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.3.9.4 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of CHOICES HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

21. Section 2.9.6.1 shall be amended by adding a new Section 2.9.6.1.6 and renumbering the remaining Sections accordingly, including any references thereto.

2.9.6.1.6 The CONTRACTOR shall compute Care Coordination CHOICES-related timelines as follows;

2.9.6.1.6.1 The day of the initiating event (e.g., receipt of a referral or receipt of the outbound 834 enrollment file is not to be included in the computation;

2.9.6.1.6.2 The Calendar Day immediately following the initiating event is day one (1) of timelines utilizing calendar days. Each subsequent calendar day is included in the computation; and

2.9.6.1.6.3 The Business Day (see Section 1) immediately following the initiating event is day one (1) of timelines utilizing business days. Each subsequent business day is included in the computation.

22. Sections 2.9.6.2.3 through 2.9.6.2.3.8 shall be deleted and replaced as follows:

2.9.6.2.3 *Functions of the Single Point of Entry (SPOE)*

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TennCare and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet nursing facility level of care; and (3) for applicants seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.

2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the applicant upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system.

2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in

answering any questions the applicant may have; (2) provide information about estate recovery; (3) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (4) provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (5) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the applicant regarding the individual cost neutrality cap, including that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (8) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The listing of CHOICES HCBS and home health and/or private duty nursing services the member may need shall be used by TENNCARE or its designee to determine whether services can be provided within the member's cost neutrality cap and may be further refined based on the CONTRACTOR's comprehensive needs assessment and plan of care development processes.

2.9.6.2.3.6 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.2.3.7 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES, the member's CHOICES Group, and any applicable patient liability amounts (See Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.

2.9.6.2.3.8 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and signed risk agreement (for members in CHOICES Group 2), and the services identified by TENNCARE or its designee that the member may need upon CHOICES enrollment.

23. Sections 2.9.6.2.4 through 2.9.6.2.4.8 shall be deleted and replaced as follows:

2.9.6.2.4 *Functions of the CONTRACTOR for Members in CHOICES Group 1*

2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall reimburse such services in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility. Reimbursement for such services shall be from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) provide continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) provide continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

2.9.6.2.4.2 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).

2.9.6.2.4.3 The CONTRACTOR shall not transition members in Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2.

2.9.6.2.4.4 For purposes of the CHOICES program, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility. .

2.9.6.2.4.5 For CHOICES members approved by TENNCARE for Level II (or skilled) nursing facility services, the CONTRACTOR shall be responsible for monitoring the member's continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when Level II nursing facility services are no longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care for nursing facility services (see also Section 2.14.1.12.2).

24. Sections 2.9.6.2.5.2 and 2.9.6.2.5.3 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

25. Sections 2.9.6.2.5.8 through 2.9.6.2.5.13 shall be deleted and replaced as follows:

2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the care coordinator shall review, and revise as necessary, the member's risk assessment and risk agreement and have the member or his/her representative sign and date any revised risk agreement.

2.9.6.2.5.9 As part of the face-to-face visit, for members determined to need eligible CHOICES HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also provide member education regarding choice of contract providers for CHOICES HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.

2.9.6.2.5.10 For purposes of CHOICES HCBS, service authorizations shall include the amount, frequency, and duration of each service to be provided and the schedule at which such care is needed, as applicable; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR shall be responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, for arranging an alternative provider who is able to initiate services as authorized on or before the requested start date.

2.9.6.2.5.11 The member's care coordinator/care coordination team shall provide at least verbal notification to the member prior to initiation of CHOICES HCBS identified in the plan of care regarding any change in providers selected by the member for each CHOICES HCBS, including the reason such change has been made.

2.9.6.2.5.12 If the CONTRACTOR is unable to initiate any CHOICES HCBS in accordance with the timeframes specified herein, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.2.5.13 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities when there is a waiting list.

26. Section 2.9.6.3.1.5 through 2.9.6.3.1.5.5 shall be deleted and replaced as follows:

2.9.6.3.1.5 Periodic review (at least quarterly) of:

2.9.6.3.1.5.1 Claims or encounter data;

2.9.6.3.1.5.2 Hospital admission or discharge data;

2.9.6.3.1.5.3 Pharmacy data; and

2.9.6.3.1.5.4 Data collected through the DM and/or UM processes.

2.9.6.3.1.5.5 The CONTRACTOR may define in its policies and procedures other steps that will be taken to better assess if the members identified through means other than referral or notice of hospital admission will likely qualify for CHOICES, and may target its screening and intake efforts to a more targeted list of persons that are most likely to need and to qualify for CHOICES services.

2.9.6.3.1.5.6 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion this task when there is a waiting list.

27. Section 2.9.6.3.2 shall be deleted and replaced as follows:

2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member's current eligibility category based on information provided by TENNCARE in the outbound 834 enrollment file; for persons seeking access to CHOICES HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility category, and if not, for persons seeking to enroll in CHOICES Group 2, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS) category; (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

28. Section 2.9.6.3.3.1 shall be deleted and replaced as follows:

2.9.6.3.3.1 Documentation of at least three (3) attempts occurring over a period of no less than three (3) days to contact the member by phone (which shall include at least one (1) attempt to contact the member at the number most recently reported by the member and at least one (1) attempt to contact the member at the number provided in the referral, if different, and which shall occur at different times of the day and evening, including after business hours), followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES, shall constitute sufficient effort by the CONTRACTOR to assist a member who has been

referred for CHOICES, regardless of referral source. TENNCARE will review the CONTRACTOR's referral data, including the number of referred members the CONTRACTOR is unable to reach, and may institute additional requirements as necessary to ensure reasonable efforts to reach the member and complete the referral and intake process.

29. Section 2.9.6.3.7 shall be deleted and replaced as follows:

2.9.6.3.7 If the member does not meet the telephone screening criteria, the CONTRACTOR shall notify the member verbally and in writing in the format prescribed by TENNCARE: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall process the request as a new referral and shall conduct a face-to-face intake visit, including level of care assessment and needs assessment, within ten (10) business days of receipt of the member's written request, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

30. Section 2.9.6.3.8.2 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

31. Sections 2.9.6.3.9 through 2.9.6.3.18 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in facilitating gathering of categorical/financial documentation needed by DHS; (4) provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (5) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for members who want to receive nursing facility services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality

cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; and (8) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

2.9.6.3.10 If the member does not meet appear to meet CHOICES enrollment criteria, the care coordinator may advise the member verbally: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; but shall also advise the member (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to a fair hearing.

2.9.6.3.10.1 The decision to discontinue the CHOICES intake process must be made by the member or the member's representative and the CONTRACTOR shall not encourage the member or member's representative to discontinue the process;

2.9.6.3.10.2 Upon the member's decision to continue the CHOICES intake, the care coordinator shall continue the intake process and complete all required activities, including submission of the level of care to TENNCARE; or

2.9.6.3.10.3 Upon the member's decision to discontinue the CHOICES intake process, the care coordinator shall, in the manner prescribed by TENNCARE, document the member's decision to terminate the CHOICES intake process, including the member's or representative's signature and date. The CONTRACTOR shall maintain this documentation in the member's record and provide a copy to the member/representative.

2.9.6.3.10.4 The CONTRACTOR shall provide the member with information about how to initiate a new CHOICES screening and intake process in the future.

2.9.6.3.11 If, during the face-to-face intake visit the member or the member's representative elects to terminate the intake process for any other reason (e.g., estate recovery, patient liability, or does not need the services available through CHOICES), the care coordinator shall, in the manner prescribed by TENNCARE, document the member's decision to terminate the CHOICES intake process, including the member's or representative's signature and date. The CONTRACTOR shall maintain this documentation in the member's record and provide a copy to the member/representative.

2.9.6.3.11.1 The decision to discontinue the CHOICES intake process must be made by the member or the member's representative and the CONTRACTOR shall not encourage the member or member's representative to discontinue the process;

2.9.6.3.11.2 The CONTRACTOR shall provide the member with information about how to initiate a new CHOICES screening and intake process in the future.

2.9.6.3.12 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within ten (10) business days of

receipt of such referral, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

2.9.6.3.13 For members identified by the CONTRACTOR as potentially eligible for CHOICES by means other than referral, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within thirty (30) days of identification of the member as potentially eligible for CHOICES. For persons identified through notification of hospital admission, the CONTRACTOR shall coordinate with the hospital discharge planner to determine whether long-term care services may be needed upon discharge, and if so, complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.

2.9.6.3.14 Once completed, the CONTRACTOR shall submit the level of care and, for members requesting CHOICES HCBS, documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap to TENNCARE as soon as possible but no later than five (5) business days of the face-to-face visit. The CONTRACTOR shall make every effort to obtain supporting documentation required for the level of care in a timely manner and shall document in writing the cause of any delay in the submission of the required documentation to TENNCARE, including the CONTRACTOR's actions to mitigate such delay. The CONTRACTOR shall be responsible for ensuring that the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status based on information gathered, at a minimum, from the member, his or her representative, the Care Coordinator's direct observations, and the history and physical or other medical records which shall be submitted with the application. The CONTRACTOR shall note in the level of care any discrepancies between these sources of information, and shall provide explanation regarding how the CONTRACTOR addressed such discrepancies in the level of care.

2.9.6.3.15 If the member is seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 and the enrollment target for CHOICES Group 2 has been reached, the CONTRACTOR shall notify TENNCARE, at the time of submission of the level of care and needs assessment and plan of care, as appropriate, whether the person shall be placed on a waiting list for CHOICES Group 2. If the CONTRACTOR wishes to enroll the person in CHOICES Group 2 as a cost effective alternative (CEA) to nursing facility care that would otherwise be provided, the CONTRACTOR shall submit to TENNCARE the following:

2.9.6.3.15.1 A written summary of the CONTRACTOR's CEA determination, including an explanation of the member's circumstances which warrant the immediate provision of nursing facility services unless CHOICES HCBS are immediately available.

2.9.6.3.15.2 TENNCARE may request additional information as needed to confirm the CONTRACTOR's CEA determination and/or provider capacity to meet the member's needs, and shall, only upon receipt of satisfactory documentation, enroll the member in CHOICES.

2.9.6.3.16 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility services if CHOICES

HCBS are not immediately available; (3) determining whether the person wants nursing facility services if CHOICES HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in Group 2 as a CEA (see Section 2.9.6.3.13.1).

2.9.6.3.17 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.3.18 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES and, if the member is enrolled in CHOICES, the member's CHOICES Group and applicable patient liability amounts (see Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and see Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.

2.9.6.3.19 For all newly enrolled CHOICES Group 1 members, the CONTRACTOR shall reimburse 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, except that the CONTRACTOR may reimburse a lesser level of service which such lesser level of service is billed by the facility.

2.9.6.3.20 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 CHOICES HCBS.

2.9.6.3.20.1 For purposes of the CHOICES program, service authorizations for CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility.

2.9.6.3.20.2 The CONTRACTOR shall provide at least verbal notice to the member prior to initiation of CHOICES HCBS identified in the plan of care regarding any change in providers selected by the member for each CHOICES HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a member in the nursing facility or community-based residential alternative setting requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.

2.9.6.3.20.3 If the CONTRACTOR is unable to initiate any long-term care service within the timeframes specified in this Agreement, the CONTRACTOR shall issue written notice to

the member, documenting the service(s) that will be delayed, the reasons for the delay and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.3.20.4 For members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving nursing facility or community-based residential alternative services from a contract provider, the CONTRACTOR shall authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving services in a nursing facility or community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

2.9.6.3.20.5 For members receiving nursing facility services, the care coordinator shall participate as appropriate in the nursing facility's care planning process (see Section 2.9.6.5.1) and may supplement the facility's plan of care as necessary (see Section 2.9.6.6.1).

2.9.6.3.20.6 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2.

2.9.6.3.20.7 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless: (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.3.20.8 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1.

2.9.6.3.21 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities for persons when there is a waiting list.

32. Section 2.9.6.4.4 shall be deleted and replaced as follows:

2.9.6.4.4 The CONTRACTOR may utilize a care coordination team approach to performing care coordination activities prescribed in Section 2.9.6. For each CHOICES member, the CONTRACTOR's care coordination team shall consist of the member's care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of CHOICES members. Care coordination teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling CHOICES care coordination functions. The CONTRACTOR shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams; the tasks that shall be performed directly by the care coordinator as specified in this Agreement, including needs assessment, development of the plan of care, and all minimum care coordination contacts; the tasks that may be performed by the care coordinator or the care coordination team; measures taken to ensure that the care coordinator remains the member's primary point of contact for the CHOICES program and related issues; escalation procedures to elevate issues to the care coordinator in a timely manner; and measures taken to ensure that if a member needs to reach his/her care coordinator specifically, calls that require immediate attention by a care coordinator are handled by a care coordinator and calls that do not require immediate attention are returned by the member's care coordinator the next business day. The CONTRACTOR may elect to utilize specialized intake coordinators or intake teams for initial needs assessment and care planning activities. All intake activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator. Should the CONTRACTOR elect to utilize specialized intake coordinators or intake teams, the CONTRACTOR shall develop policies and procedures which specify how the contractor will coordinate a seamless transfer of information from the intake coordinator or team to the member's care coordinator.

33. Section 2.9.6.6.1.1 shall be amended by deleting the phrase "/care coordination team".

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's file.

34. Section 2.9.6.6.2.4 shall be deleted and replaced as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning,

and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled on the basis of Immediate Eligibility who shall have access to services beyond the limited package of CHOICES HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, and the schedule at which such care is needed, as applicable; members enrolled on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

35. Section 2.9.6.6.2.5.11 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

36. Section 2.9.6.6.2.6 shall be amended by adding a new sentence as follows:

2.9.6.6.2.6 The member's care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any updates. The care coordinator shall also sign and date the plan of care, along with any updates.

37. Sections 2.9.6.6.2.8 and 2.9.6.6.2.9 shall be deleted and replaced as follows:

2.9.6.6.2.8 Within five (5) business days of completing a reassessment of a member's needs, the member's care coordinator shall update the member's plan of care as appropriate, and the CONTRACTOR shall authorize and initiate CHOICES HCBS in the updated plan of care. The CONTRACTOR shall comply with requirements for service authorization in Section 2.9.6.2.5.10, change of provider in Section 2.9.6.2.5.11, and notice of service delay in Section 2.9.6.2.5.12.

2.9.6.6.2.9 The member's care coordinator shall inform each member of his/her eligibility end date and educate members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members receiving CHOICES HCBS will be contacted by TENNCARE or its designee near the date a redetermination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

38. Section 2.9.6.7.2.1 shall be amended by deleting the phrase "in CHOICES Group 1".

2.9.6.7.2.1 Members who are waiting for placement in a nursing facility;

39. Sections 2.9.6.8 through 2.9.6.8.22 shall be deleted and replaced as follows:

2.9.6.8 Nursing Facility-to-Community Transition

2.9.6.8.1 The CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

2.9.6.8.1.1 Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;

2.9.6.8.1.2 Identification through the care coordination process, including but not limited to: assessments, information gathered from nursing facility staff or participation in Grand Rounds (as defined in Section 1); and

2.9.6.8.1.3 Review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.

2.9.6.8.2 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral a care coordinator conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.3 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification a care coordinator conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.4 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections 2.9.6.8.2 and 2.9.6.8.3 above) or within fourteen (14) days of identification through the care coordination process, the care coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.

2.9.6.8.5 As part of the transition assessment, the care coordinator shall conduct a risk assessment using a tool and protocol specified by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall begin to develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk as part of the plan of care. The risk agreement shall include the frequency and type of care coordinator contacts that exceed the minimum contacts required (see Section 2.9.6.9.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. The member's care coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator shall explain to the member the individual cost neutrality cap and notification process and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the CONTRACTOR will assist with transition to a more appropriate care delivery setting.

2.9.6.8.6 For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator shall notify them in accordance with the specified transition assessment protocol.

2.9.6.8.7 For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.

2.9.6.8.8 The care coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.

2.9.6.8.9 As part of transition planning, prior to the member's physical move to the community, the care coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections 2.9.6.8.18 and 2.9.6.8.17.

2.9.6.8.10 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

2.9.6.8.11 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from

approval of the transition plan, except under extenuating circumstances which must be documented in writing.

2.9.6.8.12 The member's care coordinator shall also complete a plan of care that meets all criteria described in Section 2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive needs assessment, completing and signing the risk agreement and making a final determination of cost neutrality. The plan of care shall be authorized and initiated prior to the member's transition to the community.

2.9.6.8.13 The CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).

2.9.6.8.14 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 effective as of the planned transition date.

2.9.6.8.15 The member's care coordinator/care coordination team shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.

2.9.6.8.16 For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator/care coordination team shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care, and shall take immediate action to resolve any service gaps (see definition in Section 1).

2.9.6.8.17 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the care coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.

2.9.6.8.18 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the care coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the care coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the care coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-

face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

2.9.6.8.19 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.

2.9.6.8.20 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the care coordinator.

2.9.6.8.21 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.

2.9.6.8.22 To facilitate nursing facility to community transition, the CONTRACTOR may elect to use specialized transition coordinators or transition teams. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

2.9.6.8.23 The CONTRACTOR shall implement policies and processes necessary to ensure that it is aware when a member is admitted to or discharged from a NF in order to facilitate care planning and as seamless a transition as possible, and to ensure timely notification to TENNCARE and other entities (e.g., DHS) as appropriate.

2.9.6.8.23.1 The CONTRACTOR shall require NFs to notify the CONTRACTOR of all NF discharges, transfers between NFs, or elections of hospice services in a NF.

2.9.6.8.23.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF; b) DHS of all NF discharges and transfers between NFs; and c) receiving NFs of all applicable level of care information when a member is transferring between NFs.

2.9.6.8.23.3 The CONTRACTOR shall conduct a census at least semi-annually at no less than 120-day intervals or as frequently as necessary to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.

2.9.6.8.23.4 The CONTRACTOR shall monitor all short-term NF stays for Group 2 members and shall ensure that the member is transitioned from Group 2 to Group 1 at any time a) it is determined that the stay will not be short-term and the member will not transition back to the community; and b) prior to exhausting the 90-day short-term NF benefit covered for CHOICES Group 2 members.

40. Section 2.9.6.9.1.1 shall be amended by adding a new Section 2.9.6.9.1.1.5 as follows and renumbering the existing Section 2.9.6.9.1.1 accordingly, including any references thereto.

2.9.6.9.1.1.5 In the manner prescribed by TENNCARE, facilitate transfers between nursing facilities which, at a minimum, includes notification to the receiving facility of the member's level of care, and notification to DHS; and

41. The newly renumbered Section 2.9.6.9.1.1.6 shall be amended by adding a new Section 2.9.6.9.1.1.6.5 as follows and renumbering the existing Section 2.9.6.9.1.1.6 accordingly, including any references thereto.

2.9.6.9.1.1.6.5 Frequent emergency department utilization; or

42. Section 2.9.6.9.2.1.2 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

43. Section 2.9.6.9.2.1.5 shall be deleted and replaced as follows:

2.9.6.9.2.1.5 For members in CHOICES Group 2, each time a member's plan of care is updated to change the level or type of service, document in accordance with TENNCARE policy that the projected total cost of CHOICES HCBS, home health care and private duty nursing is less than the member's cost neutrality cap. If a member's medical condition has changed such that a different cost neutrality cap may be appropriate, the CONTRACTOR shall, in the manner prescribed by TENNCARE, submit to TENNCARE a request to update the member's cost neutrality cap, including documentation specified by TENNCARE to support such request. The CONTRACTOR shall monitor utilization to identify members who may exceed the cost neutrality cap and to intervene as necessary to maintain the member's community placement. The CONTRACTOR shall also educate members in CHOICES Group 2 about the cost neutrality cap and what will happen if the cap is met;

44. Sections 2.9.6.9.2.1.6 and 2.9.6.9.2.1.7 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

45. Section 2.9.6.9.2.1.15 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

46. Sections 2.9.6.9.3.1.1 and 2.9.6.9.3.1.1.1 shall be deleted and replaced as follows:

2.9.6.9.3.1.1 In the manner prescribed by TENNCARE, conduct a level of care reassessment at least annually and within five (5) business days of the CONTRACTOR's becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility.

2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care or if the assessment was prompted by a request by a member, a member's representative or caregiver or another entity for a change in level of services, the level of care shall be forwarded to TENNCARE for determination;

47. Section 2.9.6.9.4.3.2 through 2.9.6.9.4.3.8 shall be deleted and replaced as follows:

2.9.6.9.4.3.2 Members who are newly admitted to a nursing facility when the admission has not been authorized or arranged by the CONTRACTOR, shall receive a face-to-face visit from their care coordinator within ten (10) days of notification of admission.

2.9.6.9.4.3.3 Members in CHOICES Group 2 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section 2.9.6.8.

2.9.6.9.4.3.4 Within five (5) business days of scheduled initiation of services, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 who begin receiving CHOICES HCBS after the date of enrollment in CHOICES to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.9.4.3.5 Within five (5) business days of scheduled initiation of CHOICES HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.9.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) shall receive a face-to-face visit from their care coordinator at least twice a year with an interval of at least one-hundred and twenty (120) days between visits.

2.9.6.9.4.3.7 Members in CHOICES Group 2 shall be contacted by their care coordinator at least monthly either in person or by telephone with an interval of at least fourteen (14) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

2.9.6.9.4.3.8 Members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly either in person or by telephone with an interval of at least sixty (60) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator a minimum of two (2) times per year with an interval of at least one-hundred (120) days between visits.

48. Section 2.9.6.9.6.3.3 through 2.9.6.9.6.3.7 shall be deleted and replaced as follows:

2.9.6.9.6.3.3 Written confirmation of the member's decision regarding participation in consumer direction of eligible CHOICES HCBS;

2.9.6.9.6.3.4 For members in CHOICES Group 2, a completed risk assessment and a risk agreement signed and dated by the member or his/her representative;

2.9.6.9.6.3.5 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, and a determination by the CONTRACTOR that the projected cost of CHOICES HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap; and

49. Section 2.9.6.9.6.4.1 through 2.9.6.9.6.4.3 shall be deleted and replaced as follows:

2.9.6.9.6.4.1 For CHOICES members age 21 and older in Groups 1 and 2, a Freedom of Choice form signed and dated by the member or his/her representative;

2.9.6.9.6.4.2 Evidence that a care coordinator provided the member with CHOICES member education materials (see Section 2.17.7 of this Agreement), reviewed the materials, and provided assistance with any questions;

2.9.6.9.6.4.3 Evidence that a care coordinator provided the member with education about the member's ability to use an advance directive and documentation of the member's decision;

50. Section 2.9.6.10 through 2.9.6.10.14 shall be deleted and replaced as follows:

2.9.6.10 Additional Requirements for Care Coordination Regarding Consumer Direction of eligible CHOICES HCBS

2.9.6.10.1 In addition to the roles and responsibilities otherwise specified in this Section 2.9.6, the CONTRACTOR shall ensure that the following additional care coordination functions related to consumer direction of eligible CHOICES HCBS are fulfilled.

2.9.6.10.2 The CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.6.10.3 If a member elects not to receive eligible CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, the CONTRACTOR shall document this decision, including date and member/member's representative's signature, in the manner specified by TENNCARE.

2.9.6.10.4 If a member is interested in participating in consumer direction of eligible CHOICES HCBS and the member does not intend to appoint a representative, the care coordinator shall determine the extent to which the member may require assistance to direct his/her services (see Section 2.9.7.4.5). If the care coordinator determines that the member requires assistance to direct his/her services, based upon the results of a completed self-assessment instrument developed by TENNCARE, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf (see Section 2.9.7.4.5.1).

2.9.6.10.5 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1) and that a representative agreement is completed and signed by the member prior to forwarding a referral to the FEA (see Section 2.9.7.4.7).

2.9.6.10.6 For members electing to participate in consumer direction, forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS: (1) within two (2) business days of signing the representative agreement; or (2) if a representative is not designated by the member, within two (2) business days of completion of the self-assessment instrument and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care.

2.9.6.10.7 For members electing to participate in consumer direction, the member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.

2.9.6.10.8 For members electing to participate in consumer direction, the member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in consumer- directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care

2.9.6.10.9 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, as applicable, shall be signed by the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

2.9.6.10.10 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that, for members participating in consumer direction, the member's supports broker is invited to participate in these meetings.

2.9.6.10.11 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for consumer directed services shall include authorized service, authorized units of service, including amount, frequency and duration and the schedule at which services are needed, start and end dates, and service code(s).

2.9.6.10.12 The member's care coordinator/care coordination team shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction of eligible CHOICES HCBS (see Section 2.9.7.3.4).

2.9.6.10.13 The CONTRACTOR shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.

2.9.6.10.14 The care coordinator shall determine a member's interest in enrolling in or continuing to participate in consumer direction annually and shall document the member's decision in the member's plan of care.

2.9.6.10.15 If at anytime abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

51. Section 2.9.6.11.5 shall be deleted and replaced as follows:

2.9.6.11.5 While care coordination staffing ratios are not specified, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Care Coordination Staffing Plan, including a variance of twenty (20) percent or more from the planned staffing ratio. TENNCARE may request changes in the CONTRACTOR's Care Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient care coordination staff to properly and timely perform its obligations under this Agreement.

52. Sections 2.9.6.11.12 through 2.9.6.11.12.27 shall be deleted and replaced as follows:

2.9.6.11.12 The CONTRACTOR shall provide initial training to newly hired care coordinators and ongoing training at least annually to care coordinators. Initial training topics shall include at a minimum:

2.9.6.11.12.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3, including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, the expenditure

cap for Group 3, and the limited benefit package for members enrolled on the basis of Immediate Eligibility;

2.9.6.11.12.2 Facilitating CHOICES enrollment for current members;

2.9.6.11.12.3 Level of care and needs assessment and reassessment, development of a person-centered plan of care, and updating the plan of care including training on the tools and protocols;

2.9.6.11.12.4 Development and implementation of back-up plans;

2.9.6.11.12.5 Risk assessment and development of a member-specific risk agreement;

2.9.6.11.12.6 Consumer direction of eligible CHOICES HCBS;

2.9.6.11.12.7 Self-direction of health care tasks;

2.9.6.11.12.8 Coordination of care for duals;

2.9.6.11.12.9 Electronic visit verification;

2.9.6.11.12.10 Conducting a home visit and use of the monitoring checklist;

2.9.6.11.12.11 How to immediately identify and address service gaps;

2.9.6.11.12.12 Management of critical transitions (including hospital discharge planning);

2.9.6.11.12.13 Nursing facility diversion;

2.9.6.11.12.14 Nursing facility to community transitions, including training on tools and protocols;

2.9.6.11.12.15 Management of transfers between nursing facilities and CBRA facilities, including adult care homes;

2.9.6.11.12.16 Facilitation of transitions between CHOICES Groups;

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

2.9.6.11.12.18 Alzheimer's, dementia and cognitive impairments;

2.9.6.11.12.19 Traumatic brain injury;

2.9.6.11.12.20 Physical disabilities;

2.9.6.11.12.21 Disease management;

2.9.6.11.12.22 Behavioral health;

2.9.6.11.12.23 Evaluation and management of risk;

2.9.6.11.12.24 Identifying and reporting abuse/neglect (see Section 2.24.4);

2.9.6.11.12.25 Critical incident reporting (see Section 2.15.7);

2.9.6.11.12.26 Fraud and abuse, including reporting fraud and abuse;

2.9.6.11.12.27 Advance directives and end of life care;

2.9.6.11.12.28 HIPAA/HITECH;

2.9.6.11.12.29 Cultural competency;

2.9.6.11.12.30 Disaster planning; and

2.9.6.11.12.31 Available community resources for non-covered services.

53. Section 2.9.6.12.1.2 shall be amended by adding the words "level of care" in front of the word "reassessments" as follows:

2.9.6.12.1.2 Level of care assessments and level of care reassessments occur on schedule and are submitted to TENNCARE in accordance with requirements in Section 2.9.6.9.3.1.1;

54. Section 2.9.6.12.3 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

55. Section 2.9.6.12 shall be amended by adding a new Section 2.9.6.12.4 and renumbering the existing Sections accordingly, including any references thereto.

2.9.6.12.4 The CONTRACTOR shall require, and shall conduct readiness review activities as necessary to confirm that the EVV system vendor has a plan in place and will be compliant with all ICD-10 requirements in a timely manner;

56. Section 2.9.7 through 2.9.7.1.3.10 shall be deleted and replaced as follows:

2.9.7 **Consumer Direction of Eligible CHOICES HCBS**

2.9.7.1 General

2.9.7.1.1 The CONTRACTOR shall offer consumer direction of eligible CHOICES HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, homemaker, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons electing consumer direction of eligible CHOICES HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction or that is not a CHOICES HCBS shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible CHOICES HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of eligible CHOICES HCBS is voluntary. Members may

elect to participate in or withdraw from consumer direction of eligible CHOICES HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible CHOICES HCBS or to withdraw from participation in consumer direction of eligible CHOICES HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of eligible CHOICES HCBS.

2.9.7.1.2 Consumer direction is a process by which eligible CHOICES HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized CHOICES HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Care rather than the TennCare Solutions Units, which manages medical appeals pertaining to TennCare benefits (i.e., services).

2.9.7.1.3 Members who participate in consumer direction of eligible CHOICES HCBS choose either to serve as the employer of record of their workers or to designate a representative (see definition below in Section 2.9.7.2.1) to serve as the employer of record on his/her behalf. As the employer of record the member or his/her representative is responsible for the following:

2.9.7.1.3.1 Recruiting, hiring and firing workers;

2.9.7.1.3.2 Determining workers' duties and developing job descriptions;

2.9.7.1.3.3 Scheduling workers;

2.9.7.1.3.4 Supervising workers;

2.9.7.1.3.5 Evaluating worker performance and addressing any identified deficiencies or concerns;

2.9.7.1.3.6 Setting wages from a range of rates established by TENNCARE;

2.9.7.1.3.7 Training workers to provide personalized care based on the member's needs and preferences;

2.9.7.1.3.8 Ensuring that workers deliver only those services authorized, and reviewing and approving hours worked by consumer-directed workers;

2.9.7.1.3.9 Reviewing and ensuring proper documentation for services provided; and

2.9.7.1.3.10 Developing and implementing as needed a back-up plan to address instances when a scheduled worker is not available or fails to show up as scheduled.

57. Sections 2.9.7.2.2 and 2.9.7.2.4 shall be amended by adding the words "eligible CHOICES in front of the word "HCBS".

58. Sections 2.9.7.3.2, 2.9.7.3.2.1, 2.9.7.3.3, and 2.9.7.3.11.6 shall be amended by adding the words "eligible CHOICES in front of the word "HCBS".

59. Section 2.9.7.4 through 2.9.7.4.10.13 shall be deleted and replaced as follows:

2.9.7.4 Needs Assessment/Plan of Care Process

2.9.7.4.1 A CHOICES member may choose to direct needed eligible CHOICES HCBS at anytime: during CHOICES intake, through the needs assessment/reassessment and plan of care and plan of care update processes; and outside of these processes. The care coordinator shall assess the member's needs for eligible CHOICES HCBS per requirements in Sections 2.9.6.2.4, 2.9.6.3 and 2.9.6.5, as applicable. The care coordinator shall use the plan of care process (including updates) to identify the eligible services that the member will direct and to facilitate the member's enrollment in consumer direction of eligible CHOICES HCBS.

2.9.7.4.2 The CONTRACTOR shall obtain from the member a signed statement regarding the member's decision to participate in consumer direction of eligible CHOICES HCBS.

2.9.7.4.2.1 The care coordinator shall assist the member in identifying which of the needed eligible CHOICES HCBS shall be consumer directed, provided by contract providers or a combination of both, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.3 If the member intends to direct one or more needed eligible CHOICES HCBS, throughout the period of time that consumer direction is being initiated, the CONTRACTOR shall arrange for the provision of needed CHOICES HCBS through contract providers in accordance with 2.9.6. The care coordinator shall obtain from the member his/her choice of contract providers who will provide CHOICES HCBS until such time as workers are secured and ready to begin delivering care through consumer direction.

2.9.7.4.3.1 If a member has been assessed to need companion care services, the CONTRACTOR shall identify non-residential services that will offer interim support to address the member's needs and assist the member in obtaining contract providers for these services.

2.9.7.4.4 The CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of eligible CHOICES HCBS, based upon the

results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member's file.

2.9.7.4.5.1 If, based on the results of the self-assessment the care coordinator determines that a member requires assistance to direct his/her services, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf.

2.9.7.4.5.2 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to deny participation in consumer direction because a care coordinator has determined that the health, safety and welfare of the member would be in jeopardy if the member participates in consumer direction without a representative but the member does not want to appoint a representative to assist in directing his/her services. The CONTRACTOR shall abide by TENNCARE's decision.

2.9.7.4.6 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1 of this Agreement) and that a representative agreement is completed and signed by the member and the person prior to forwarding a referral to the FEA (see Section 2.9.7.4.7 below).

2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each by type; and care coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of eligible CHOICES HCBS. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.

2.9.7.4.8 Within two (2) business days of receipt of the referral, the FEA shall assign a supports broker to the member, notify the care coordinator of the assignment and provide the name and contact information of the supports broker.

2.9.7.4.9 Within five (5) days of receipt of the referral, the FEA shall contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating consumer direction of eligible CHOICES HCBS.

2.9.7.4.10 *Back-up Plan for Consumer Direction and Updated Risk Assessment/Risk Agreement*

2.9.7.4.10.1 The FEA shall assist the member/representative as needed in developing a back-up plan for consumer direction that adequately identifies how the member/representative will

address situations when a scheduled worker is not available or fails to show up as scheduled. The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services.

2.9.7.4.10.2 The member/representative (as applicable) may not elect, as part of the back-up plan, to go without services.

2.9.7.4.10.3 The back-up plan for consumer direction shall include the names and telephone numbers of contacts (workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. The FEA shall confirm with these persons and/or organizations to confirm their willingness and availability to provide care when needed, document confirmation in the member's file and forward a copy of the documentation to the CONTRACTOR.

2.9.7.4.10.5 The member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.

2.9.7.4.10.6 The FEA shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to address the member's needs, and notify the care coordinator immediately regarding any concerns with the back-up plan or the member's care.

2.9.7.4.10.7 The FEA shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the FEA shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the member's care coordinator.

2.9.7.4.10.8 The FEA and the CONTRACTOR shall each file a copy of the back-up plan for consumer direction in the member's file.

2.9.7.4.10.9 The member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

2.9.7.4.10.10 The CONTRACTOR shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. Once a referral has been made to the FEA for consumer direction, the member's supports broker should be involved in risk assessment and risk planning activities whenever possible. The new or updated risk agreement, as applicable, shall be signed by the member or his/her representative (as applicable). The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file.

2.9.7.4.10.11 The FEA shall notify the member's care coordinator immediately when there are changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk, or changes to the plan of care or risk agreement.

2.9.7.4.10.12 The FEA shall assist the CONTRACTOR in identifying and addressing in the risk assessment and plan of care processes any additional risk associated with the member participating in consumer direction.

2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the member's supports broker is invited to participate in these meetings.

60. Section 2.9.7.5 through 2.9.7.5.10.1 shall be deleted and replaced as follows:

2.9.7.5 <u>Authorizations for Consumer Directed Services and Service Initiation</u>

2.9.7.5.1 Consumer direction of eligible CHOICES HCBS shall not be initiated until all requirements are fulfilled including but not limited to the following: (1) the FEA verifies that the member's employer and related documentation is in order; (2) the FEA verifies that workers meet all qualifications, including participation in required training; (3) there is a signed service agreement specific to each individual worker (see Section 2.9.7.6.6 of this Agreement); and (4) the CONTRACTOR issues to the FEA an authorization for consumer directed services (see 2.9.7.5.6 below) for each service.

2.9.7.5.2 The FEA shall work with the member to determine the appropriate level of assistance necessary to recruit, interview and hire workers and provide the assistance.

2.9.7.5.3 Once potential workers are identified, the FEA shall verify that a potential worker meets all applicable qualifications (see Section 2.9.7.6.1 of this Agreement).

2.9.7.5.4 The FEA shall ensure that a service agreement is signed between the member or member's representative and his/her worker within five (5) business days following the FEA's verification that a worker meets all qualifications.

2.9.7.5.5 The FEA shall periodically update the member's care coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

2.9.7.5.6 The provision of consumer directed services shall begin as soon as possible but no longer than sixty (60) days from the date of the CONTRACTOR's referral to the FEA, except due to circumstances beyond the control of the FEA. Prior to beginning the provision of consumer directed services, the FEA shall notify the CONTRACTOR that all requirements have been fulfilled, including verification of all worker qualifications, criminal background checks, signed service agreements, and that the member is ready to begin consumer direction of eligible CHOICES HCBS. Within two (2) business days of receipt of the notification from the FEA, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services. Each authorization for consumer directed services shall include authorized service; authorized units of service, including amount, frequency and duration and, as appropriate, the schedule at which services are needed; start and end dates; and service code(s). Authorized units of service in a service authorization should reflect the units of measure specified by TENNCARE for the benefit (e.g. visits, hours, days). The CONTRACTOR shall submit authorizations electronically on at least a daily basis using the agreed upon data interface (which may include a standard electronic file transfer, the FEA's web portal technology, the EVV system, or any combination thereof).

2.9.7.5.7 If initiation of consumer directed services does not begin within sixty (60) days from the date of the CONTRACTOR's referral to the FEA, the FEA shall contact the CONTRACTOR regarding the cause of the delay and provide appropriate documentation to demonstrate efforts to meet the timeframe. The CONTRACTOR shall determine the appropriate next steps, including but not limited to whether additional time is needed or if the member is still interested in participating in consumer direction of eligible CHOICES HCBS.

2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall contact the FEA who shall assist the member or his/her representative as needed in implementing the member's back-up plan for consumer direction.

2.9.7.5.9 Within five (5) business days of the scheduled start date of consumer directed services as specified in the authorization of consumer directed services, a member of the care coordinator

team shall contact the member or his/her representative to confirm that services are being provided and that the member's needs are being met.

2.9.7.5.10 On an ongoing basis, in addition to requirements specified above in 2.9.7.5.3 – 2.9.7.5.9 above:

2.9.7.5.10.1 The CONTRACTOR shall develop and forward to the FEA a new authorization for consumer directed services when the following occur: a change in the number of service units, or the frequency or duration of service delivery, or a change in the schedule at which services are needed; or a change in the services to be provided through consumer direction, including the provision of a new service through consumer direction or termination of a service through consumer direction.

61. Sections 2.9.7.7.1, 2.9.7.7.4.1, and 2.9.7.8.5 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

62. Section 2.9.7.9 through 2.9.7.9.9 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS" and by adding the words "outbound 834" in front of the words "enrollment file".

63. Section 2.9.7.9.10.2 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS.

64. Section 2.9.14.6 shall be deleted and replaced and Section 2.9.14.7 shall be deleted in its entirety and the remaining Section 2.9.14 shall be renumbered accordingly, including any references thereto.

2.9.14.6 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TennCare and CHOICES, and assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process;

65. Section 2.11.1.4.1 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

66. Section 2.11.1.8.2 shall be amended by deleting the phrase ", including services".

2.11.1.8.2 The CONTRACTOR is not required to provide non-emergency transportation for HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program, except as provided in Section 2.11.1.8.1 above.

67. Section 2.11.6.3, 2.11.6.4, 2.11.6.6.2, 2.11.6.6.5, 2.11.6.6.7 and 2.11.6.6.8 shall be amended by adding the word "CHOICES" in front of the word HCBS.

68. Section 2.11.8.4 through 2.11.8.4.2 shall be deleted and replaced as follows:

2.11.8.4 Credentialing of Long-Term Care Providers

2.11.8.4.1 The CONTRACTOR shall develop and implement a process for credentialing and recredentialing long-term care providers. The CONTRACTOR's process shall, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, the CONTRACTOR shall ensure that all long-term care providers, including those credentialed/recredentialed in accordance with NCQA Standards and Guidelines for the Accreditation of MCOs, meet applicable State requirements, as specified by TENNCARE in State Rule, this Agreement, or in policies or protocols.

2.11.8.4.1.1 The CONTRACTOR shall develop policies that specify by HCBS provider type the credentialing process, the recredentialing process including frequency, and ongoing provider monitoring activities.

2.11.8.4.1.1.1 Ongoing CHOICES HCBS providers must be recredentialed at least annually;

2.11.8.4.1.1.2 All other CHOICES HCBS providers (e.g., pest control and assistive technology), must be recredentialed, at a minimum, every three (3) years.

2.11.8.4.1.2 At a minimum, credentialing of LTC providers shall include the collection of required documents, including disclosure statements, and verification that the provider:

2.11.8.4.1.2.1 Has a valid license or certification for the services it will contract to provide as required pursuant to State law or rule, or TENNCARE policies or protocols;

2.11.8.4.1.2.2 Is not excluded from participation in the Medicare or Medicaid programs;

2.11.8.4.1.2.3 Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

2.11.8.4.1.2.4 Has policies and processes in place to conduct, in accordance with Federal and State law and rule and TENNCARE policy, criminal background checks, which shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), on all prospective employees who will deliver CHOICES HCBS and to document these in the worker's employment record;

2.11.8.4.1.2.5 Has a process in place to provide and document initial and ongoing education to its employees who will provide services to CHOICES members that includes, at a minimum:

2.11.8.4.1.2.5.1 Caring for Elderly and Disabled population;

2.11.3.4.1.2.5.2 Abuse and neglect prevention, identification and reporting;

2.11.3.4.1.2.5.3 Critical incident reporting;

2.11.3.4.1.2.5.4 Documentation of service delivery;

2.11.3.4.1.2.5.5 Use of the EVV System; and

2.11.8.4.1.2.5.6 Any other training requirements specified by TENNCARE in State Rule, this Agreement, or in policies or protocols.

2.11.8.4.1.2.6 Has policies and processes in place to ensure:

2.11.8.4.1.2.6.1 Compliance with the CONTRACTOR's critical incident reporting and management process; and

2.11.8.4.1.2.6.2 Appropriate use of the EVV system.

2.11.8.4.1.3 At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable), and compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV.

2.11.8.4.1.4 For both credentialing and recredentialing processes, the CONTRACTOR shall conduct a site visit, unless the provider is located out of state, in which case the CONTRACTOR may waive the site visit and document the reason in the provider file.

2.11.8.4.1.5 At a minimum, the CONTRACTOR shall reverify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.

69. Section 2.12.9.38 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

70. Section 2.12.9 shall be amended by adding a new Section 2.12.9.63 as follows:

2.12.9.63 The provider, subcontractor or any other entity agrees to abide by the Medicaid laws, regulations and program instructions that apply to the provider. The provider, subcontractor or any other entity understands that payment of a claim by TennCare or a TennCare Managed Care Contractor and/or Organization is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the provider's , subcontractor's or any other entity's compliance with all applicable conditions of participation in Medicaid. The provider, subcontractor or any other entity understands and agrees that each claim the provider, subcontractor or any other entity submits to TennCare or a TennCare Managed Care Contractor and/or Organization constitutes a certification that the provider, subcontractor or any other entity has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein.

71. Sections 2.12.12 through 2.12.12.10 and Section 2.12.13 shall be deleted and replaced as follows:

2.12.12 The provider agreement with a CHOICES HCBS provider shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:

2.12.12.1 Require the CHOICES HCBS provider to provide at least thirty (30) days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers;

2.12.12.2 In the event that a CHOICES HCBS provider change is initiated for a member, require that, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR, which may exceed thirty (30) days from the date of notice to the CONTRACTOR;

2.12.12.3 Specify that reimbursement of a CHOICES HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the member's plan of care as authorized by the CONTRACTOR, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service;

2.12.12.4 Require CHOICES HCBS providers to immediately report any deviations from a member's service schedule to the member's care coordinator;

2.12.12.5 Require CHOICES HCBS providers to use the electronic visit verification system specified by the CONTRACTOR in accordance with the CONTRACTOR's requirements;

2.12.12.6 Require that upon acceptance by the CHOICES HCBS provider to provide approved services to a member as indicated in the member's plan of care, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by the CONTRACTOR in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;

2.12.12.7 Require CHOICES HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service;

2.12.12.8 Prohibit CHOICES HCBS providers from requiring a member to choose the provider as a provider of multiple services as a condition of providing any service to the member;

2.12.12.9 Prohibit CHOICES HCBS providers from soliciting members to receive services from the provider including:

2.12.12.9.1 Referring an individual for CHOICES screening and intake with the expectation that,, should CHOICES enrollment occur, the provider will be selected by the member as the service provider; or

2.12.12.9.2 Communicating with existing CHOICES members via telephone, face-to-face or written communication for the purpose of petitioning the member to change CHOICES providers;

2.12.12.10 Require CHOICES HCBS providers to comply with critical incident reporting and management requirements (see Section 2.15.7 of this Agreement); and

2.12.12.11 Shall not require the CHOICES HCBS provider to have liability insurance in excess of TENNCARE requirements in effect prior to the implementation of CHOICES.

2.12.13 The provider agreement with a CHOICES HCBS provider to provide PERS, assistive technology, minor home modifications, or pest control shall meet the requirements specified in Sections 2.12.9, 2.12.10, and 2.12.12 except that these provider agreements shall not be required to meet the following requirements: Section 2.12.9.9 regarding emergency services; Section 2.12.9.11 regarding delay in prenatal care; Section 2.12.9.12 regarding CLIA; Section 2.12.9.38 regarding hospital protocols; Section 2.12.9.40 regarding reimbursement of obstetric care; Section 2.12.9.52.2 regarding prior authorization of pharmacy; and Section 2.12.9.53 regarding coordination with the PBM.

72. Sections 2.13.3 through 2.13.3.3 and Sections 2.13.4 through 2.13.4.4 shall be deleted and replaced as follows:

2.13.3 **Nursing Facility Services**

2.13.3.1 The CONTRACTOR shall reimburse contract nursing facility providers at the per diem rate specified by TENNCARE, net of any applicable patient liability amount (see Section 2.6.7).

2.13.3.2 The CONTRACTOR shall reimburse non-contract nursing facility providers as specified in TennCare rules and regulations, net of any applicable patient liability amount (see Section 2.6.7).

2.13.3.3 If, prior to the end date specified by TENNCARE in its approval of Level II nursing facility services, the CONTRACTOR determines that the nursing facility is providing Level I and not Level II nursing facility services, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility for the lesser level of services only when such lesser level of services is billed by the nursing facility or upon approval from TENNCARE of a reduction in the member's level of care or reimbursement as reflected on the outbound 834 enrollment file.

2.13.3.4 The CONTRACTOR shall, upon receipt of notification from TENNCARE of a retrospective adjustment of a nursing facility's per diem rate(s), without requiring any action on the part of the provider, reprocess affected claims and provide any additional payment due within sixty

(60) days of receipt of such notification. The CONTRACTOR shall, upon notification in the outbound 834 enrollment file of retroactive patient liability amounts or retroactive adjustments in patient liability amounts, without requiring any action on the part of the provider, reprocess affected claims and provide any additional payment due within thirty (30) days of receipt of such notification. The CONTRACTOR shall not require that NFs resubmit affected claims in order to process these adjustments.

2.13.4 **CHOICES HCBS**

2.13.4.1 For covered CHOICES HCBS and for CHOICES HCBS that exceed the specified benefit limit and are provided by the CONTRACTOR as a cost effective alternative (see Section 2.6.5), the CONTRACTOR shall reimburse contract HCBS providers, including community-based residential alternatives, at the rate specified by TENNCARE.

2.13.4.2 The CONTRACTOR shall reimburse non-contract CHOICES HCBS providers as specified in TennCare rules and regulations.

2.13.4.3 For other HCBS that are not otherwise covered but are offered by the CONTRACTOR as a cost effective alternative to nursing facility services (see Section 2.6.5), the CONTRACTOR shall negotiate the rate of reimbursement.

2.13.4.4 The CONTRACTOR shall reimburse consumer-directed workers in accordance with Sections 2.9.6.7 and 2.26 of this Agreement.

73. Section 2.13 shall be amended by adding a new Section 2.13.8 as follows and renumbering the existing Section 2.13.8 through 2.13.20 accordingly, including any references thereto.

2.13.8 Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs)

Upon notification by TENNCARE, the CONTRACTOR shall reimburse contracted FQHCs/RHCs using prospective payment system rates and wraparound payments for qualifying visits in accordance with TENNCARE developed policies and protocols. TENNCARE's policies and protocols shall be based on federal regulations.

74. The renumbered Sections 2.13.11.3 and 2.13.12.3 shall be amended by adding the words "outbound 834" in front of the words "enrollment file".

75. The renumbered Section 2.13.13 shall be amended by adding the phrase "in accordance with the requirements of this agreement" to the end of the last sentence.

2.13.13 **Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider**

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider. The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6) and that were authorized by the CONTRACTOR in accordance with the requirements of this agreement.

76. The renumbered Section 2.13.21 shall be amended by adding the phrase "eligible CHOICES" in front of the word "HCBS".

77. Section 2.14.1.12 through 2.14.1.12.2 shall be deleted and replaced as follows:

2.14.1.12 Nursing Facility

2.14.1.12.1 The CONTRACTOR shall ensure that reimbursement of level II nursing facility care is provided for CHOICES members who have been determined by TENNCARE to be eligible for Level II nursing facility care for the period specified by TENNCARE, except when a lesser level of services is billed by the nursing facility. The CONTRACTOR shall monitor the member's condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires Level II nursing facility care, the CONTRACTOR may submit to TENNCARE a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility for the lesser level of services only when such lesser level of services is billed by the nursing facility or upon approval from TENNCARE of a reduction in the member's level of care or reimbursement as reflected on the outbound 834 enrollment file. .

78. Section 2.14.5 through 2.14.5.4 shall be deleted and replaced as follows:

2.14.5 **Authorization of Long-Term Care Services**

2.14.5.1 The CONTRACTOR shall have in place an authorization process for covered long-term care services and cost effective alternative services that is separate from but integrated with the CONTRACTOR's prior authorization process for covered physical health and behavioral health services (See section 2.9.6 of this Agreement).

2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility.

2.14.5.3 The CONTRACTOR shall authorize and initiate CHOICES HCBS for CHOICES members within the timeframes specified in Sections 2.9.2, 2.9.3, and 2.9.6 of this Agreement.

2.14.5.4 The CONTRACTOR shall not require that CHOICES HCBS be ordered by a treating physician, but may consult with the treating physician as appropriate regarding the member's physical health, behavioral health, and long-term care needs and in order to facilitate communication and coordination regarding the member's physical health, behavioral health, and long-term care services.

2.14.5.5 For non-CHOICES members receiving care in non-contract nursing facilities authorized by the CONTRACTOR as a cost-effective alternative, the CONTRACTOR shall reimburse services in accordance with its authorization until such time that the member is no longer eligible for services, is enrolled in CHOICES, or such care is no longer medically necessary or cost-effective.

79. Section 2.14.8.1 shall be deleted and replaced as follows:

2.14.8.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. With respect to CHOICES HCBS which are not primarily medical in nature, pertinent medical history shall include assessments, case notes, and documentation of service delivery by HCBS providers. Medical information from the treating physician may also be pertinent in better understanding the member's functional needs. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

80. Section 2.15.1.6 shall be amended by adding new Sections 2.15.1.6.1 through 2.15.1.6.3 as follows.

2.15.1.6 The CONTRACTOR shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified.

2.15.1.6.1 The CONTRACTOR may be required to conduct special focus studies as requested by TENNCARE.

2.15.1.6.2 The CONTRACTOR shall collect data on race and ethnicity. As part of the QM/QI program description, the CONTRACTOR shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected.

2.15.1.6.3 The CONTRACTOR shall include QM/QI activities to improve healthcare disparities identified through data collection.

81. Section 2.15.4 shall be deleted and replaced as follows:

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs. The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years.

82. Section 2.15.6 shall be amended by adding a new Section 2.15.6.3 as follows:

2.15.6.3 The CONTRACTOR shall submit annually the Relative Resource Use (RRU) data to TENNCARE within ten (10) business days of receipt from NCQA. The CONTRACTOR shall submit both the Regional and National RRU results.

83. Sections 2.15.7 through 2.15.7.6 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

84. Section 2.17.2 shall be amended by adding a new Section 2.17.2.10 as follows:

2.17.2.10 All educational materials (brochures, scripts etc.) shall be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information.

85. Section 2.17.4.6, 2.17.4.7.15 and 2.17.7.3.22 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

86. Section 2.17.7.3.2, 2.17.7.3.10, 2.17.7.3.15, 2.17.7.3.16, 2.17.7.3.18, 2.17.7.3.19 and 2.17.8.6 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

87. Section 2.18.4.6 shall be deleted and replaced as follows:

2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, TENNderCare, prior authorization and referral requirements, care coordination, and the CONTRACTOR's provider network. For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall maintain a dedicated queue to assist long-term care providers with enrollment, service authorization, or reimbursement questions or issues and shall ensure that long-term care providers are appropriately notified regarding how to access the dedicated queue for assistance. Such period may be extended as determined necessary by TENNCARE.

88. Section 2.18.5.3.3 shall be deleted and replaced as follows:

2.18.5.3.3 Description of the CHOICES program including but not limited to who qualifies for CHOICES (including the three CHOICES groups and enrollment targets for CHOICES Groups 2 and 3); how to enroll in CHOICES; long-term care services available to each CHOICES Group (including benefit limits, cost neutrality cap for members in Group 2, and the expenditure cap for members in Group 3); consumer direction of eligible CHOICES HCBS; self-direction of health care tasks; the level of care assessment and reassessment process; the needs assessment and reassessment processes; requirement to provide services in accordance with an approved plan of care including the amount, frequency, duration and scope of each service in accordance with the member's service schedule; service authorization requirements and processes; the role of the care coordinator; the role and responsibilities of long-term care and other providers; requirements regarding the electronic visit verification system and the provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff; how to submit clean claims; and documentation requirements for CHOICES HCBS providers;

89. Section 2.18.5.3.13 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

90. Section 2.18.5.3 shall be amended by adding a new Section 2.18.5.3.14 and renumbering the existing Section accordingly, including any references thereto.

2.18.5.3.14 Information for CHOICES HCBS providers regarding prohibition of facilitating CHOICES referrals with the expectation of being selected as the service provider or petitioning existing CHOICES members to change CHOICES providers.

91. Section 2.18.6.3.16 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

92. Section 2.18.6 shall be amended by adding a new Section 2.18.6.5 and renumbering the existing Section accordingly, including any references thereto.

2.18.6.5 The CONTRACTOR shall develop and implement a training plan to educate long-term care providers regarding compliance with ICD-10 requirements;

93. The renumbered Sections 2.18.6.7 and 2.18.6.8 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

2.18.6.7 For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall conduct monthly education and training for CHOICES HCBS providers regarding the use of the EVV system. Such period may be extended as determined necessary by TENNCARE.

2.18.6.8 The CONTRACTOR shall provide education and training on documentation requirements for CHOICES HCBS.

94. Section 2.21.5 through 2.21.5.2 shall be deleted and replaced as follows:

2.21.5 **Patient Liability**

2.21.5.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for members via the outbound 834 enrollment file.

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 CHOICES HCBS, the CONTRACTOR shall collect applicable patient liability amounts.

2.21.5.3 When TENNCARE notifies the CONTRACTOR of patient liability amounts for CHOICES members via the outbound 834 enrollment file at any time other than the beginning of the month, then the CONTRACTOR shall determine and apply the prorated portion of patient liability for that month.

95. Section 2.22.4.4 through 2.22.4.4.2 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

96. Section 2.22.6.3 and 2.22.6.4.13 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

97. Section 2.22.6.4.5 shall be deleted and replaced as follows:

2.22.6.4.5 Allowed payment amount agrees with contracted rate and the terms of the provider agreement;

98. Section 2.22.7.1.8 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

99. Section 2.23.5.1 shall be amended by adding the words "outbound 834" in front of the words "enrollment files".

100. Section 2.23.13.1 shall be amended by adding the words "outbound 834" in front of the words "enrollment file".

101. Section 2.24.3.2 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

102. Section 2.26.6 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS.

103. Section 2.29.1 shall be amended by adding a new Section 2.29.1.11 as follows:

2.29.1.11 The CONTRACTOR shall be required to have appropriate staff member(s) attend certain on-site meetings held at TennCare offices or at other sites as requested and designated by TENNCARE.

104. Sections 2.29.2 through 2.29.2.2 shall be deleted and replaced as follows:

2.29.2 **Licensure and Background Checks**

2.29.2.1 Except as specified in this Section 2.29.2.1 regarding the FEA, the CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law. The FEA shall be responsible for ensuring that consumer-directed workers are qualified to provide eligible CHOICES HCBS in accordance with TENNCARE requirements.

2.29.2.2 Except as specified in this Section 2.29.2.2 regarding the FEA, the CONTRACTOR is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR conducts background checks in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers.

105. Section 2.30.1.4 shall be deleted and replaced as follows:

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE and shall ensure that all reports are complete and accurate. The CONTRACTOR shall be subject to liquidated damages as specified in Section 4.20.2.1.1 for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by TENNCARE until all deficiencies have been corrected. Except as otherwise specified by TENNCARE, all reports shall be specific to the Grand Region covered by this Agreement.

106. The lead in paragraph of Section 2.30.6.5 shall be deleted and replaced as follows:

2.30.6.5 The CONTRACTOR shall submit a monthly *CHOICES HCBS Late and Missed Visits Report* for CHOICES members regarding the following CHOICES HCBS: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include information on specified measures, which shall include but not be limited to the following:

107. Item (2) of Section 2.30.6.6 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

108. Section 2.30.7.1 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

109. Section 2.30.7.5 shall be deleted and replaced as follows:

2.30.7.5 The CONTRACTOR shall submit an *Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness* that shall include the CONTRACTOR's plan for monitoring behavioral health providers to ensure that they comply with the timeliness of appointment standards that are outlined for behavioral health in Attachment III for routine specialty MD (behavioral health) care and Attachment V for Outpatient Non-MD behavioral health services. This plan will be submitted for approval to the Bureau of TennCare by December 31 of each year and shall identify methods for determining how they will monitor and evaluate providers for compliance, develop corrective action plans for compliance, maintain records of audits for timeliness and describe efforts to improve timeliness of appointments. The minimum data elements required are identified in Attachment IX, Exhibit D.

110. Section 2.30.7 shall be amended by adding a new Section 2.30.7.6 and renumbering the existing Sections 2.30.7.6 and 2.30.7.7 accordingly, including any references thereto.

2.30.7.6 The CONTRACTOR shall submit a Quarterly *Behavioral Health Appointment Timeliness Summary Report* that includes a quarterly summary of activities based on the Annual Plan for Monitoring of Behavioral Health Appointment Timeliness (See Section 2.30.7.5) The minimum data elements required are identified in Attachment IX, Exhibit D.

111. Section 2.30.9 shall be amended by adding a new Section 2.30.9.5 as follows:

2.30.9.5 Upon notification by TENNCARE, the CONTRACTOR shall submit a weekly *Administrative Services Only Invoice Report* for all payments to clinics designated as Federally Qualified Health Clinics or Rural Health Clinics.

112. Section 2.30.11 shall be amended by adding a new Section 2.30.11.7 as follows:

2.30.11.7 By October 1, 2011, the CONTRACTOR is required to submit a *Data Collection Strategy Report* that describes how they intend to collect data in accordance with the HHS initiative to implement a multifaceted health disparities data collection strategy. (HHS Action Plan to Reduce Racial and Ethnic Health Disparities, April 8, 2011) The report must include the CONTRACTOR's plans for collection and reporting of data in five specific demographic categories in accordance with the new provisions of the Affordable Care Act: race, ethnicity, gender, primary language, and disability status. The following OMB (minimum standards) categories for race and ethnicity (Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 1997) must be used: Hispanic or Latino or Not Hispanic or Latino; American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White. CONTRACTOR plans must also include how the collected data will be used to integrate information across systems in order to enhance TennCare data, any system changes that will be needed, and timelines for implementation. Following review of the CONTRACTOR's plan, TENNCARE will set an implementation date for revised data collection and data reporting.

113. Item (2) of Section 2.30.16.4 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

114. Section 3.1.2 shall be amended by adding the phrase ", any payments related to FQHC/RHC costs" as follows:

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, any incentive payments (if applicable), any payments related to FQHC/RHC costs and any payments that offset the CONTRACTOR's cost for the development and implementation of an electronic visit verification system (EVV) (see Section 3.13) are payment in full for all services provided pursuant to this Agreement. TENNCARE shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at TCA 56-32-101 *et seq.* or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at TCA 56-51-101 *et seq.* or any subsequent amendments thereto. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

115. Section 3.4.3.7.1.1.1 shall be amended as follows:

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 outbound 834 enrollment file on the date of their official transfer.

116. Section 3.7.1 shall be amended by adding a new Section 3.7.1.5 and 3.7.1.6, deleting and replacing the renumbered Section 3.7.1.7 as follows and updating all references accordingly.

3.7.1.5 The CONTRACTOR shall not be entitled to a CHOICES capitation payment for any calendar month during which a CHOICES member does not receive nursing facility services or ongoing CHOICES HCBS, except under extenuating circumstances which must be reported to TENNCARE on the CHOICES Utilization Report. Acceptable extenuating circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. The determination that the CONTRACTOR is not entitled to a CHOICES capitation payment shall be made by TENNCARE based on information provided in monthly CHOICES Utilization Reports and/or upon review and analysis of the CONTRACTOR's encounter data. For any month in which the CONTRACTOR is not entitled to the CHOICES capitation payment, the capitation payment will be retroactively adjusted to reflect the appropriate non-CHOICES capitation rate applicable for that month.

3.7.1.6 The effective date of the CHOICES capitation payment may be retroactively adjusted by TENNCARE in any instance in which the CONTRACTOR fails to initiate nursing facility services or ongoing CHOICES HCBS within the timeframes prescribed in 2.9.6., in which case, the effective date of the CHOICES capitation payment will be the date of initiation of nursing facility or ongoing HCBS.

3.7.1.7 Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process, or pursuant to other processes as established by TENNCARE.

117. Section 3.9.2.6 shall be deleted and replaced as follows:

3.9.2.6 The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies shall be in accordance with Section 3.9.2.1 as described above. If the CONTRACTOR has attained a two and one half percent (2.5%) withhold and TENNCARE subsequently determines the CONTRACTOR is not in compliance with a requirement of this Agreement, TENNCARE will provide written notice of such determination and TENNCARE will re-institute the retention of the withhold as described in Section 3.9.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount will continue for each subsequent month so long as the identified deficiencies have not been corrected. These funds will not be distributed to the CONTRACTOR unless it is determined by TENNCARE the CONTRACTOR has come into compliance with the Agreement requirement(s) within six (6) months of TENNCARE identifying these deficiencies. For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies which the CONTRACTOR has been given written notice of by TENNCARE, the withhold for the four (4) consecutive months will be paid to the CONTRACTOR upon TENNCARE determination that the deficiency(s) was corrected. However, any amounts withheld by TENNCARE for six (6) consecutive months for the same or similar compliance deficiency(s) shall be permanently retained by TENNCARE on the first day after the sixth consecutive month period and shall not be paid to the CONTRACTOR. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TENNCARE may declare the MCO ineligible for future distribution of the ten percent (10%) incentive withhold and may continue to permanently retain any

amounts withheld by TENNCARE for six (6) consecutive months. Such ineligibility will continue for each month TENNCARE determines the same or similar specified deficiency(s) continues to exist. Once a CONTRACTOR corrects the deficiency(s), TENNCARE may reinstate the MCO's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TENNCARE determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the CONTRACTOR.

118. Section 3 shall be amended by adding a new Section 3.11 as follows and renumbering the existing Sections 3.11 through 3.14 accordingly including any references thereto.

3.11 Reimbursement of Cost related Payments for FQHCs/RHCs

Upon notification by TENNCARE, TENNCARE shall reimburse the CONTRACTOR for FQHC/RHC cost outside of the capitation rates in accordance with TENNCARE developed policies and protocols and based on the CONTRACTOR's reported Administrative Services Only weekly invoice (See Section 2.30.9.5). TENNCARE's policies and protocols shall be based on federal regulations.

119. The renumbered Section 3.15.1.1 shall be deleted and replaced as follows:

3.15.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed four billion, three hundred thirty five million, one hundred fifty five thousand, five hundred forty one ($4,335,155,541.00).

120. The opening paragraph of Section 4.1 shall be deleted and replaced as follows:

4.1 NOTICE

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States certified mail, postage prepaid, return receipt requested; in person; by facsimile, email or other electronic means, including but not limited to providing notice through computer databases, software or other systems made available to the CONTRACTOR by TENNCARE; or by other means, so long as proof of delivery and receipt is given, and the cost of delivery is borne by the notifying party, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

121. Section 4.2.1 and 4.2.2 shall be deleted and replaced as follows:

4.2.1 **Term of the Agreement**

This Agreement, including any amendments and any changes made by notice to adjust the capitation rates, shall be effective commencing on August 15, 2006 and ending on December 31, 2014.

4.2.2 **Term Extension**

The State reserves the right to extend this Agreement for an additional period or periods of time representing increments of no more than one (1) year and a total term of no more than five (5) years,

provided that the State notifies the CONTRACTOR in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. In accordance with an approved exception request, TENNCARE may extend this Agreement through December 31, 2014. An extension of the term of this Agreement will be effected through an amendment to the Agreement.

122. Section 4.20.2.1.1 shall be amended by adding the word "incomplete" as follows:

4.20.2.1.1 For each day that a report or deliverable is late, incorrect, incomplete, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one hundred dollars ($100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.

123. The liquidated damage chart in Section 4.20.2.2.7 shall be amended by deleting and replacing A.20 and adding new damages A.21 through A.26 as follows:

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 and dated 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
A.21	Failure to process a referral by or on behalf of the CONTRACTOR's member for enrollment in the CHOICES program in accordance with specified requirements and timelines (see Section 2.9.6)		$500 per day for each day the CONTRACTOR was delinquent in completing the referral
A.22	Failure to initiate disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days in accordance with 2.6.1.5.7.		$1000 per occurrence plus $1000 for each month for which the capitation payment amount must be adjusted
A.23	Failure to facilitate transitions between CHOICES Groups accordance with 2.9.6.9.1.1.5		$500 per occurrence

A.24	Failure to ensure that all TennCare data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of TennCare enrollee protected health information ancillary Business Associate Agreement executed between the parties		$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by CONTRACTOR's failure to comply with the terms of this Agreement, the CONTRACTOR shall be liable for all costs associated with the provision of such safeguard services.
A.25	Failure to seek express written approval from TENNCARE, including the execution of the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party for any purpose other than the purpose of this Agreement (See ancillary Business Associate Agreement executed between the parties)		$500 per enrollee per occurrence

A.26	Failure by the CONTRACTOR to prevent the use or disclosure of TennCare enrollee data or TennCare confidential in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement executed between the parties)		$1,000 per enrollee per occurrence

124. Section C of the Program Issues/Damages chart of Section 4.20.2.2.7 shall be amended by adding a new C.3 as follows and renumbering the existing C.3 through C.7 as follows including any references thereto.

C.3	Failure to have subject appropriate staff member(s) attend onsite meetings as requested and designated by TENNCARE		$1000 per appropriate staff person per meeting as requested by TENNCARE

125. Section 4.20.2.4 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

126. Section 4 shall be amended by adding new Sections 4.38 and 4.39 as follows and the existing Sections 4.38 and 4.39 shall be renumbered accordingly including any references thereto.

4.38 Prohibition of Payments for Items or Services Outside the United States

Section 6505 of the Affordable Care Act amends section 1902(a) of the Social Security Act (the Act), and requires that a State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States (U.S.). This section of the Affordable Care Act is effective January 1, 2011, unless the Secretary determines that implementation requires State legislation, other than legislation appropriating funds, in order for the plan to comply with this provision.

For purposes of implementing this provision, section 1101(a)(2) of the Act defines the term "United States" when used in a geographical sense, to mean the "States." Section 1101(a)(1) of the Act defines the term "State" to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

Further, this provision prohibits payments to telemedicine providers located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Additionally, payments to pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are not permitted.

The Centers for Medicare & Medicaid Services (CMS) will require that, in the case of providers that have provided medical assistance or covered items and/or services to Medicaid beneficiaries under

the State plan or under a waiver program, and are requesting reimbursement from the State Medicaid program, such reimbursement must be provided to financial institutions or entities located within the U.S. If it is found that payments have been made to financial institutions or entities outside of the U.S., States must recover these payments and must forward any Federal match for such payments to CMS consistent with the guidelines specified in Federal regulations at 42 CFR Part 433.

Any audits of claims by CMS to assure compliance with this provision will begin no earlier than June 1, 2011 and will only review claims submitted on or after June 1, 2011 for compliance with this section.

4.39 Federal Funding Accountability and Transparency Act (FFATA)

This Agreement requires the CONTRACTOR to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The CONTRACTOR is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the CONTRACTOR provides information to the State as required.

The CONTRACTOR shall comply with the following:

4.39.1 Reporting of Total Compensation of the CONTRACTOR's Executives.

4.39.1.1 The CONTRACTOR shall report the names and total compensation of each of its five most highly compensated executives for the CONTRACTOR's preceding completed fiscal year, if in the CONTRACTOR's preceding fiscal year it received:

4.39.1.1.1 Eighty percent (80%) or more of the CONTRACTOR's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and sub awards); and

4.39.1.1.2 $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and sub awards); and

4.39.1.1.3 The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.).

Executive means officers, managing partners, or any other employees in management positions.

4.39.1.2 Total compensation means the cash and noncash dollar value earned by the executive during the CONTRACTOR's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

4.39.1.2.1 Salary and bonus.

4.39.1.2.2 Awards of stock, stock options, and stock appreciation rights. Use the dollar amount

recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

4.39.1.2.3 Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

4.39.1.2.4 Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

4.39.1.2.5 Above-market earnings on deferred compensation which is not tax qualified.

4.39.1.2.6 Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

4.39.2 The CONTRACTOR must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.

4.39.3 If this Agreement is amended to extend its term, the CONTRACTOR must submit an executive total compensation report to the State by the end of the month in which the amendment to this Agreement becomes effective.

4.39.4 The CONTRACTOR will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Agreement. More information about obtaining a DUNS Number can be found at: http://fedgov.dnb.com/webform/

4.39.5 The CONTRACTOR's failure to comply with the above requirements is a material breach of this Agreement for which the State may terminate this Agreement for cause. The State will not be obligated to pay any outstanding invoice received from the CONTRACTOR unless and until the CONTRACTOR is in full compliance with the above requirements.

127. "Timely Claims Processing", "Claims Payment Accuracy", and "HCBS Provider Network" Performance Measures in Attachment VII shall be amended by adding the word "CHOICES" in front of the word "HCBS".

128. The Performance Measure regarding "Initial appointment timeliness for behavioral health services" in Attachment XII shall be deleted in its entirety.

129. Item 17 and 120 in Attachment VIII shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".

130. Attachment VIII shall be amended by deleting and replacing Items 129, 131, and 132; adding new Items 130 and 138 as follows and renumbering the existing items accordingly.

129. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness (see Section 2.30.7.5)

Amendment Number 8 (cont.)

130. Quarterly Behavioral Health Appointment Timeliness Summary Report (see Section 2.30.7.6)

131. CHOICES Qualified Workforce Strategies Report (see Section 2.30.7.7)

132. FQHC Reports (see Section 2.30.7.8)

138. Administrative Services Only Invoice Report (See Section 2.30.9.5)

131. Exhibit D of Attachment IX shall be deleted and replaced as follows:

ATTACHMENT IX, EXHIBIT D
Annual Plan and Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness

I. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness

The *Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness* required in Section 2.30.7.5 will be submitted to the Bureau of TennCare by December 31 of each year, with the first annual plan due for submission by December 31, 2011. This deliverable shall include, at a minimum, the following elements:

1. A plan for how the CONTRACTOR monitors and evaluates behavioral health providers for compliance with the timeliness of appointment standards that are outlined for behavioral health in Attachment III for routine MD (behavioral health) specialty care and Attachment V for Outpatient Non-MD behavioral health services.
2. The plan shall include a delineation of methodologies used for monitoring and evaluation:
   a. The plan shall include at minimum, at least one method that incorporates either a phone survey or on-site audit.
   b. The report shall include the frequency of surveys/audits, number of site visits, and types of providers monitored, by (MD and non-MD), and by age group (under 18 years of age and 18 years of age and over) as well as number of phone calls or number of appointments evaluated for timeliness, by type (MD/non-MD) and (under 18 years of age and 18 years of age and over) for each provider.
3. This report will also include the types of correspondence with providers regarding timeliness of appointments; number of performance reports issued to providers, number of Corrective Action Plans (CAPs) issued to providers and results of follow-up to the CAPs.
4. A summary of overall findings will include a summary of results across providers; how representative the sample of surveys/site visits are of the overall volume of services provided; analysis of data collection and identification and resolution of problems, including percentage of compliance with standards in Attachments III and V, as outlined in # 1 above.
5. Description of record keeping, including results of audits and surveys, and requests for corrective action plans submitted to providers.
6. A summary of other methods used to monitor the timeliness of behavioral health appointments.

II. Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness

The Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness as required in Section 2.30.7.6. will be due within thirty (30) days after completion of the quarter. This deliverable shall include, at a minimum, a summary and update of the quarterly activities and results outlined in the Annual Plan for the

Monitoring of Behavioral Health Appointment Timeliness as required in Section 2.30.7.5, including strategies, results and outcomes of efforts to improve timeliness of appointments.

132. Section A.4.3.2.4.1 of Attachment XI shall be amended by deleting "one-quarter (1/4th)" and replacing it with "one-third (1/3)".

A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-third (1/3) of a mile.

133. Sections A.12.5 and A.12.6 of Attachment XI shall be deleted and replaced as follows:

A.12.5 The CONTRACTOR shall provide Department of Intellectual and Developmental Disabilities (DIDD) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide MR waiver transportation services (either as an individual transportation service or as a component of residential and/or day services) pursuant to provider qualifications applicable for such providers which shall be determined by DIDD. These providers shall only provide covered NEMT services to members receiving HCBS MR waiver services from the provider. The CONTRACTOR shall reimburse these providers for covered NEMT to TennCare covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided though a HCBS MR waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. Except as specified in A.12.5, this includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

134. Section A.14 of Attachment XI shall be amended by adding a new sentence as follows:

A.14 **PAYMENT FOR NEMT SERVICES**

A.14.1 **General**

In addition to requirements in the Agreement regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment. In addition to the requirements of this Agreement and this Attachment, the CONTRACTOR shall have a policy to address fuel price adjustments.

135. Item 13 of Exhibit A of Attachment XI shall be deleted and replaced as follows:

13. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, dental services, and institutional services. TennCare covered services includes TENNderCare services. For purposes of NEMT, TennCare covered services does not include CHOICES HCBS or 1915(c) MR waiver services.

136. Attachment XII shall be amended by adding a new Exhibit E and F as follows:

EXHIBIT E
CAPITATION RATES
UnitedHealthCare
EFFECTIVE July 1, 2010

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.53
	Age 1 - 13	$ 85.18
	Age 14 - 20 Female	$ 232.03
	Age 14 - 20 Male	$ 126.74
	Age 21 - 44 Female	$ 380.65
	Age 21 - 44 Male	$ 243.95
	Age 45 – 64	$ 454.67
	Age 65 +	$ 443.40
Uninsured/Uninsurable	Age Under 1	$ 523.22
	Age 1 - 13	$ 77.66
	Age 14 - 19 Female	$ 108.26
	Age 14 – 19 Male	$ 97.53
Disabled	Age < 21	$ 1,441.01
	Age 21 +	$ 955.97
Duals/Waiver Duals	All Ages	$ 187.78
Priority Add-On	Age < 21	$ 386.66
	Age 21 +	$ 386.66
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

EXHIBIT F
CAPITATION RATES
UnitedHealthCare
EFFECTIVE January 1, 2011

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 523.52
	Age 1 - 13	$ 94.47
	Age 14 - 20 Female	$ 251.48
	Age 14 - 20 Male	$ 165.60
	Age 21 - 44 Female	$ 400.87
	Age 21 - 44 Male	$ 262.92
	Age 45 – 64	$ 474.75
	Age 65 +	$ 446.29
Uninsured/Uninsurable	Age Under 1	$ 523.24
	Age 1 - 13	$ 84.00
	Age 14 - 19 Female	$ 119.17
	Age 14 – 19 Male	$ 117.86
Disabled	Age < 21	$ 1,627.60
	Age 21 +	$ 1,080.82
Duals/Waiver Duals	All Ages	$ 235.67
CHOICES Rate (Effective upon the CHOICES Implementation Date)	CHOICES Duals	$ 4,281.62
	CHOICES Non-Duals	$ 5,625.27

Amendment Number 8 (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, 2011.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A Emkes/CP
Mark Emkes
Commissioner

DATE: 6/1/11

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

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

DATE: 5/31/11

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A Emkes
Mark Emkes
Commissioner

JUN 28 2011

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: Justin P. Wilson/MKO
Justin P. Wilson
Comptroller

DATE: 7/7/11

CONTRACT SUMMARY SHEET

021406

CONTRACT NOT PAID THROUGH EDISON

RFS #	Contract #
318.66-051	FA-07-16937-07
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	June 30, 2011	Subrecipient	93.778 Dept. of Health and Human Services/Title XIX

Mark Each TRUE Statement

[ ] 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
					$ -
TOTAL:	$ 1,057,925,836.00	$ 2,288,023,870.00	$ -	$ -	$ 3,345,949,706.00

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
		$ -
TOTAL:	$ 3,345,949,706.00	$ -
End Date	June 30, 2011	June 30, 2011

State Agency Fiscal Contact & Telephone #

Scott Pierce 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 only for base contracts with contract # prefix: FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg.ID,GG,GU) [ ] Other

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

RECEIVED
JAN 7 2011
MANAGEMENT SERVICES

OCR
DEC 30 2010
RECEIVED

AMENDMENT NUMBER 7
MIDDLE
CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. 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. Sections 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 upon request and as otherwise 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 3.14.3 shall be amended by adding new text to the end as follows:

3.14.3 **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, 2008 for all non-CHOICES rate categories will be established through a competitive bid process, and the priority add-on rate and the base capitation rate for CHOICES members will be established by the State. The base capitation rates (for CHOICES and non-CHOICES members) and the 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:

<u>Supported Housing</u>

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 7 (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 7 (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+

Amendment Number 7 (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 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: Mike Morrow / SAP
M. D. Goetz, Jr.
Commissioner

DATE: 12/22/10

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY:
Scott A. Bowers
Chief Executive Officer, TennCare

DATE: 12/10/10

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mike Morrow / KS
M. D. Goetz, Jr.
Commissioner

DATE: 1/6/11

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: Justin P. Wilson / MAP
Justin P. Wilson
Comptroller

DATE: 1/13/11

CONTRACT SUMMARY SHEET

021406

CONTRACT NOT PAID THROUGH EDISON

RFS #	Contract #
318.66-051	FA-07-16937-06

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	C- or X V- 363379945 01

Service Description:

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor	CFDA #
August 15, 2006	June 30, 2011	subrecipient	93.778 Dept. of Health and Human Services/Title XIX

Mark Each if HUB Statement

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

Allotment Code	Cost Center	Object Code	Fund	Fundingcitant Code	Fundingcitant Subcitant Code
318.66	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
					$ -
TOTAL	$ 1,057,925,836.00	$ 2,288,023,870.00	$ -	$ -	$ 3,345,949,706.00

OCR RELEASED
JUL 06 2010
TO ACCOUNTS
Agency

COMPLETE FOR AMENDMENT ONLY

FY	Prev Cont/Ccs & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011	$ 989,205,835.00	
		$ -
TOTAL	$ 3,345,949,706.00	$ -
End Date	June 30, 2011	June 30, 2011

State Agency Fiscal Contact & Telephone #:

Scott Pierce 507-6415

State Agency Budget Office Approval:

Sitte

Funding Certification: Unencumbered Balance Ministry Grants, Other Nature and all encumbrances and all unexpended balances for contracts and grants which will not be paid during the biennium are hereby cancelled.

M. D. Goetz Jr

JBS

Contractor Ownership (complete only if this contract will contribute to MBE goals)

- [ ] African American
- [ ] Asian
- [ ] Person w/ Disability
- [ ] Female
- [ ] Hispanic
- [ ] Native American
- [ ] Small Business
- [x] NOT disadvantaged
- [ ] OTHER minority/disadvantaged—

Contractor Selection Method (Complete for All Procurements) (N/A for amendment or decision memorandum)

- [ ] RFP
- [x] Non-Competitive Negotiation
- [ ] Competitive Negotiation
- [ ] Negotiation w/ Government (eg.ID,GG,GU)
- [ ] Alternative Competitive Method
- [ ] Other

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

OCR
JUN 18 2010
RECEIVED

AMENDMENT NUMBER 6

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

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. **Sections 2.6.1.3, 2.6.2.3, and 2.11.1.8.2 shall be amended by deleting and replacing references to MR and/or Mental Retardation and replacing them with references to "intellectual disabilities (i.e., mental retardation).**

2. **The first sentence of Section 2.6.7.2.4 shall be amended by adding the phrase "and the member otherwise qualifies to enroll in CHOICES Group 2," after the word "member,".**

3. **Section 2.7.2.8.1.5 shall be deleted and replaced as follows:**

   2.7.2.8.1.5 The CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

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

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

5. **Section 2.9.6.11.12.14 shall be deleted and replaced as follows:**

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

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

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

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

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

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

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

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

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

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

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

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

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

2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the

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 March 1st, 2010 through the completion of the 2010 open enrollment period for enrollees who were enrolled in CHOICES on March 1, 2010.

3.4.3.7.1.1.1 CHOICES members that change MCOs during the open enrollment period will be designated as either a NF enrollee or an HCBS enrollee based upon the determination made in the eligibility file on the date of their official transfer.

3.4.3.7.1.1.2 The net transfer of CHOICES members from March 1, 2010 through May 31, 2010 will be compared to the mix of NF/HCBS enrollees in the data book assumptions. If the mix of net transfers exceeds one half (½) of one (1) percent different between the MCOs, rates will be adjusted accordingly.

3.4.3.7.1.2 A similar process will occur in May 2011, after the completion of the open enrollment period for 2011. This process will compare the effect of net transfers as compared to the mix before the 2011 open enrollment period.

3.4.3.7.1.3 This adjustment will be budget neutral to the state.

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

3.4.3.7.2 New Membership

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

3.4.3.7.2.1.1 In order to protect each MCO from adverse selection, TENNCARE will compare the distribution of new enrollees between MCOs to the regional averages. If the mix of net transfers exceeds one half (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 6 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2010.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M D Goetz Jr /SO
M. D. Goetz, Jr.
Commissioner

DATE: 6-16-10

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

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

DATE: 6/11/10

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M.D. Goetz Jr /KS
M. D. Goetz, Jr.
Commissioner

DATE: 6/22/10

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: Justin P. Wilson /SR
Justin P. Wilson
Comptroller

DATE: 6/30/10

CONTRACT SUMMARY SHEET

021406

CONTRACT NOT PAID THROUGH EDISON

TASK	CONTRACT
318.66-051	FA-07-16937-05

STATE AGENCY	STATE APPROVING UNIT
Department of Finance and Administration	Bureau of TennCare

CONTRACTOR NAME	CONTRACTOR NUMBER
UnitedHealthCare Plan of the River Valley, Inc.	C- or X V- 363379945 01

SERVICE DESCRIPTION

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

CONTRACT BEGIN DATE	CONTRACT END DATE	SUBRECIPIENT OR VENDOR	CFDA
August 15, 2006	June 30, 2011	subrecipient	93.778 Dept. of Health and Human Services/Title XIX

[ ] [ ] Contractor is on STARS

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

Allotment Code	Cost Code	Object Code	Funding Year	Funding Agency Code	Funding Unit Code
318.66	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Appropriation
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
2011	$ 292,112,483.00	$ 697,093,352.00			$ 989,205,835.00
					$ -
TOTAL	$ 1,057,925,836.00	$ 2,288,023,870.00	$ -	$ -	$ 3,345,949,706.00

OCR RELEASED
APR 19 2010
Agency
TO ACCOUNTS

FY	State Day Care Appropriation	Title XIX Match Only
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010	$ 782,905,835.00	
2011		$ 989,205,835.00
		$ -
TOTAL	$ 2,356,743,871.00	$ 989,205,835.00
Date	June 30, 2010	June 30, 2011

COMPLETE FOR AMENDMENTS ONLY

STATE AGENCY CONTACT PERSON

Scott Pierce 507-6416

STATE APPROVING UNIT APPROVAL

Scott

[illegible]

M. S. Ott RN

ABS

CONTRACTOR'S MINORITY STATUS

[ ] African American [ ] Person w/ Disability [ ] Hispanic [ ] Small Business [X] NOT disadvantaged

[ ] Asian [ ] Female [ ] Native American [ ] OTHER minority/disadvantaged—

CONTRACT SELECTION METHOD

[ ] [X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method

[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg,ID,GG,GU) [ ] Other

PROCUREMENT PROCESS SUMMARY (Complete if Alternative Competitive Method or Other)

OCR
MAR 09 2010
RECEIVED

AMENDMENT NUMBER 5

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

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. Section 1 shall be deleted and replaced as follows:

SECTION 1 - DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Agreement shall be given the meaning used in TennCare rules and regulations. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Agreement, the specific language in Sections 2 through 4 of this Agreement shall govern.

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

1. Meeting general requirements in Section 2.2;

2. Enrollment and disenrollment in accordance with Sections 2.4 and 2.5;

3. Additional services and use of incentives in Section 2.6.6;

4. Health education and outreach in Section 2.7.4;

5. Meeting requirements for coordination of services specified in Section 2.9, including care coordination for CHOICES members and the CONTRACTOR's electronic visit verification system except as otherwise provided in Section 3;

6. Establishing and maintaining a provider network in accordance with the requirements specified in Section 2.11, Attachments III, IV and V;

7. Utilization Management as specified in Section 2.14;

8. Quality Management/ Quality Improvement activities as specified in Section 2.15;

9. Production and distribution of Member Materials as specified in Section 2.17;

10. Customer service requirements in Section 2.18;

11. Complaint and appeals processing and resolution in accordance with Section 2.19;

12. Determination of recoveries from third party liability resources in accordance with Section 2.21.4;

13. Claims Processing in accordance with Section 2.22;

14. Maintenance and operation of Information Systems in accordance with Section 2.23;

15. Personnel requirements in Section 2.29;

16. Production and submission of required reports as specified in Section 2.30;

17. Administration of this Agreement in accordance with policies and procedures;

18. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;

19. Premium tax; and

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

Adult Protective Services (APS) – An office within the Tennessee Department of Human Services that investigates reports of abuse, neglect (including self-neglect) or financial exploitation of vulnerable adults. APS staff assess the need for protective services and provide services to reduce the identified risk to the adult.

Adverse Action – Any action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits.

Affiliate – Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the CONTRACTOR.

Appeal Procedure – The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rules and regulations and any and all applicable court orders and consent decrees.

Area Agency on Aging and Disability (AAAD) – The agency designated by the Tennessee Commission on Aging and Disability (TCAD) to develop and administer a comprehensive and coordinated community based system in, or serving, a defined planning and service area.

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.

Back-up Plan – A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or non-residential HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services with assistance from the FEA as needed.

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 except for behavioral services for Priority enrollees.

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

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

Benefits – The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare enrollees enrolled in the CONTRACTOR's MCO pursuant to this Agreement.

Bureau of TennCare – The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare program. For the purposes of this Agreement, Bureau of TennCare shall mean the State of Tennessee and its representatives.

Business Day – Monday through Friday, except for State of Tennessee holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate various aspects of health care.

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 and Priority Add-on 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 and priority add-on rate.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Agreement and in accordance with Section 2.9.6.

Care Coordination Unit – A specific group of staff within the MCO's organization dedicated to CHOICES that is comprised of care coordinators and care coordinator supervisors and which may also include care coordination teams.

Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in Section 2.9.6 of the Contractor Risk Agreement.

Caregiver – For purposes of CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or for consumer direction of HCBS.

CEA – Cost Effective Alternative (see Section 2.6.5 of this Agreement).

Centers of Excellence (COE) for AIDS – Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare enrollees with HIV or AIDS.

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

CFR – Code of Federal Regulations.

Child Protective Services (CPS) – A program division of the Tennessee Department of Children's Services whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
   Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

2. Group 2
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

3. Group 3
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of HCBS, are "at-risk" for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations. Group 3 will not be included in CHOICES on the date of CHOICES implementation. TENNCARE intends to include CHOICES Group 3 on January 1, 2011. TENNCARE will notify the CONTRACTOR at least sixty (60) days prior to the proposed date for including Group 3 in CHOICES. As of the date specified in that notice, the CONTRACTOR shall accept members in CHOICES Group 3 and shall implement all of the requirements in this Agreement that are applicable to CHOICES Group 3.

CHOICES Implementation Date – The date, as determined by TENNCARE, when the CONTRACTOR shall begin providing long-term care services to CHOICES members.

CHOICES Member – A member who has been enrolled by TENNCARE into CHOICES.

Clean Claim – A claim received by the CONTRACTOR for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CONTRACTOR.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

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

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

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

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

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

CMS – Centers for Medicare & Medicaid Services.

Community-Based Residential Alternatives to Institutional Care (Community-Based Residential Alternatives) – Residential services that offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

Complaint – A written or verbal expression of dissatisfaction from a member about an action taken by the CONTRACTOR or service provider other than an adverse action. The CONTRACTOR shall not treat anything as a complaint that falls within the definition of adverse action.

Confidential Information – Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is created under this Agreement. Any such information relating to individuals enrolled in the TennCare program ("TennCare members"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained under this Agreement, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All Confidential Information shall not be subject to disclosure under the Tennessee Public Records Act.

Consumer – Except when used regarding consumer direction of HCBS, an individual who uses a mental health or substance abuse service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES member participating in consumer direction of HCBS or his/her representative to provide one or more eligible HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of HCBS – The opportunity for a CHOICES member assessed to need specified types of HCBS including attendant care, personal care, homemaker, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Contract Provider – A provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide covered services.

Contractor Risk Agreement (CRA) – The agreement between the CONTRACTOR and TENNCARE regarding requirements for operation and administration of the managed care TennCare program, including CHOICES.

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including HCBS, home health, and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy.

Covered Services – See Benefits.

CRA – Contractor Risk Agreement; also referred to as "Agreement."

CRG (Clinically Related Group) – Defining and classifying consumers 18 years or older into clinically

related groups involves diagnosis, the severity of functional impairment, the duration of severe functional impairment, and the need for services to prevent relapse. Based on these criteria, there are five clinically related groups:

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

Group 2 - Persons with Severe Mental Illness (SMI)

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

Group 4 - Persons with Mild or Moderate Mental Disorder

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

Days – Calendar days unless otherwise specified.

Dental Benefits Manager (DBM) – An entity responsible for the provision and administration of dental services, as defined by TENNCARE.

DHHS – United States Department of Health and Human Services.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the enrollment file furnished by TENNCARE to the CONTRACTOR.

Electronic Visit Verification (EVV) System – An electronic system into which provider staff and consumer-directed workers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program. As it relates to CHOICES a person is eligible to receive CHOICES benefits only if he/she has been enrolled in CHOICES by TENNCARE.

Eligible HCBS – Attendant care, personal care, homemaker, in-home respite, companion care services and/or any other services specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Emergency Medical Condition – A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Employer of Record – The member participating in consumer direction of HCBS or a representative designated by the member to assume the consumer direction of HCBS functions on the member's behalf.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also).

Enrollee Marketing – Any communication, from the CONTRACTOR to a TennCare enrollee who is not enrolled in the CONTRACTOR's MCO, that can reasonably be interpreted as intended to influence the person to enroll in the CONTRACTOR's MCO, or either to not enroll in, or to disenroll from, another MCO's TennCare product.

Enrollment – The process by which a TennCare enrollee becomes a member of the CONTRACTOR's MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

Essential Hospital Services – Tertiary care hospital services to which it is essential for the CONTRACTOR to provide access. Essential hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

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

Expenditure Cap – The annual limit on expenditures for HCBS, excluding home modifications, for CHOICES members in CHOICES Group 3. The expenditure cap is $15,000.

Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the CONTRACTOR or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractor or provider to provide services on behalf of the CONTRACTOR.

Fee-for-Service – A method of making payment for health services based on a fee schedule that specifies payment for defined services.

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps CHOICES members participating in consumer direction of HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES members participating in consumer direction of HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible HCBS authorized and provided.

FQHC – Federally Qualified Health Center.

General Marketing – Any communication or activity that can reasonably be interpreted as intended to promote the CONTRACTOR, including, but not limited to, advertising, publicity, and positioning.

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

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

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

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

Grand Rounds – As used with respect to CHOICES members residing in a nursing facility, a planned quarterly meeting between nursing facility staff and MCO staff, including, at minimum, the care coordinator(s) assigned to residents of the facility conducted in order to: (1) address issues or concerns regarding members who have experienced a potential significant change in needs or circumstances or about whom the nursing facility or MCO has concerns (not necessarily all members who are residents of the facility); (2) identify any change in services or interventions for the members, including but not limited to changes in the members' plans of care or supplements to the members' plans of care; and (3) facilitate access to and coordination of physical health and/or behavioral health services needed by the members and to ensure the proper management of the members' acute and/or chronic conditions. At least two of the quarterly Grand Rounds per year shall be conducted on-site in the facility.

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

Health Maintenance Organization (HMO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 32.

HIPAA - Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HITECH - Health Information Technology for Economic and Clinical Health Act, Pub.L.111-5, Div. A, Title XIII, § 13001(a), Feb. 17, 2009, 123 Stat. 226.

Home and Community-Based Services (HCBS) – Services not covered by Tennessee's Title XIX state plan that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). HCBS does not include home health or private duty nursing services.

Hospice – Services as described in TennCare rules and regulations and 42 CFR Part 418, which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

Immediate Eligibility – A mechanism by which the State can, based on a preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered HCBS, be determined by TENNCARE to meet nursing facility level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES Group 2 based on review of the financial information provided by the applicant. Immediate eligibility shall only be for specified HCBS (no other covered services) and for a maximum of forty-five (45) days.

Individually Identifiable Health Information – Any information, including demographic information, collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual; or, with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Information System(s) (Systems) – A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Intervention – An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

Law – Statutes, codes, rules, regulations, and/or court rulings.

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

Long-Term Care – The services of a nursing facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community-Based Services (HCBS).

Long-Term Care Ombudsman Program – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Tennessee Commission on Aging and Disability (TCAD).

Managed Care Organization (MCO) – An HMO that participates in the TennCare program.

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

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health, behavioral health, and/or long-term care services to members pursuant to the following listed Sections of the Agreement:

    a. Section 2.6.1, CONTRACTOR Covered Benefits;

    b. Section 2.6.4, Second Opinions;

    c. Section 2.6.5, Use of Cost Effective Alternative Services;

    d. Section 2.7, Specialized Services except TENNderCare member and provider outreach and education, health education and outreach and advance directives;

    e. Capitated payment to licensed providers;

    f. Medical services directed by TENNCARE or an Administrative Law Judge; and

    g. Net impact of reinsurance coverage purchased by the CONTRACTOR.

2. Medical Expenses do not include:

    a. 2.6.2 TennCare Benefits Provided by TENNCARE;

    b. 2.6.7 Cost Sharing and Patient Liability;

    c. 2.10 Services Not Covered;

    d. Services eligible for reimbursement by Medicare; or

    e. The activities described in or required to be conducted in Attachments II through XI, which are administrative costs.

3. Medical expenses shall be net of any TPL recoveries or subrogation activities.

4. This definition does not apply to NAIC filings.

Medical Loss Ratio (MLR) – The percentage of capitation payment received from TENNCARE that is used to pay medical expenses.

Medical Records – All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical,

behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Member – A TennCare enrollee who enrolls in the CONTRACTOR's MCO under the provisions of this Agreement (see Enrollee, also).

Member Month – A month of coverage for a TennCare enrollee enrolled in the CONTRACTOR's MCO.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

NAIC – National Association of Insurance Commissioners.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

Non-Contract Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

Office of the Comptroller of the Treasury – The Comptroller of the Treasury is a State of Tennessee constitutional officer elected by the General Assembly for a term of two years. Statutes prescribe the comptroller's duties, the most important of which relate to audit of state and local government entities and participation in the general financial and administrative management of state government.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

One-Time HCBS – In-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

Ongoing HCBS – Community-based residential alternatives, personal care, attendant care, homemaker services, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

PASRR – Preadmission Screening and Resident Review.

Patient Liability – The amount of an enrollee's income, as determined by DHS, to be collected each month to help pay for the enrollee's long-term care services.

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member's condition.

Prepaid Limited Health Service Organization (PLHSO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 51.

Presumptive Eligibility – An established period of time (45 days) during which certain pregnant women

are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete an application for Medicaid in order to stay on the program.

Primary Care Physician – A physician responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is generally a physician who has limited his/her practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Geriatrician, or Family Practitioner. However, as provided in Section 2.11.2.4 of this Agreement, in certain circumstances other physicians may be primary care physicians if they are willing and able to carry out all PCP responsibilities in accordance with this Agreement.

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

Prior Authorization – The act of authorizing specific services or activities before they are rendered or occur.

Priority Add-on Rate – The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement as compensation for the provision of behavioral health services for Priority enrollees.

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

Privacy Breach – The acquisition, access, use, or disclosure of PHI in a manner which compromises the security or privacy of the PHI as governed by the provisions of HIPAA and other federal and state laws. For purposes of this definition, "compromises the security or privacy of the protected health information" means poses a significant risk of financial, reputational, or other harm to the individual.

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Protected Health Information (PHI) – Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Provider – An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Provider does not include consumer-directed workers (see Consumer-Directed Worker); nor does provider include the FEA (see Fiscal Employer Agent).

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between the CONTRACTOR and a provider or between the CONTRACTOR's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the CONTRACTOR's members.

Quality Management/Quality Improvement (QM/QI) – The development and implementation of strategies to assess and improve the performance of a program or organization on a continuous basis. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

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

Regulatory Requirements – Any requirements imposed by applicable federal, state or local laws, rules, regulations, court orders and consent decrees, a program contract, or otherwise imposed by TENNCARE in connection with the operation of the program or the performance required by either party under an agreement.

Representative – In general, for CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care planning and implementation and to speak and make decisions on the member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns. As it relates to consumer direction of HCBS, a person who is authorized by the member to direct and manage the member's worker(s), and signs a representative agreement. The representative for consumer direction of HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand his/her support needs; know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

Representative Agreement – The agreement between a CHOICES member electing consumer direction of HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

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

Risk Agreement – An agreement signed by a member who will receive HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member's decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.

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

Safeguarding Enrollee Information – To maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information; to protect against

any reasonably anticipated threats or hazards to the security or integrity of the information; and to protect against unauthorized uses or disclosures of the information.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Final Rule adopting Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164.

Self-Direction of Health Care Tasks – A decision by a CHOICES member participating in consumer direction to direct and supervise a paid worker delivering eligible HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible HCBS s/he is authorized to receive.

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

1. Person under the age of 18; and

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

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

Service Agreement – The agreement between a CHOICES member electing consumer direction of HCBS (or the member's representative) and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing HCBS that was not initiated by a member, including late and missed visits.

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

1. Age 18 and over; and

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

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

Shall – Indicates a mandatory requirement or a condition to be met.

Span of Control – Information systems and telecommunications capabilities that the CONTRACTOR itself operates or for which it is otherwise legally responsible according to this Agreement. The CONTRACTOR's span of control also includes Systems and telecommunications capabilities outsourced by the CONTRACTOR.

Specialty Services – Includes Essential Hospital Services, services provided by Centers of Excellence, and specialty physician services.

SSA – Social Security Administration.

SSI – Supplemental Security Income.

Start Date of Operations – The date, as determined by TENNCARE, when the CONTRACTOR shall begin providing services to members.

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Bureau of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General.

Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, disease management) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Subcontractor – Any organization or person who provides any function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

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

Supports Broker – An individual assigned by the FEA to each member who assists the member/representative in performing the employer of record functions, including, but not limited to: developing job descriptions; locating; recruiting; interviewing; scheduling; monitoring; and evaluating workers. The supports broker collaborates with, but does not duplicate, the functions of the member's care coordinator. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.

System Unavailability – As measured within the CONTRACTOR's information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

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

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
   Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).

2. Target Population Group 3: At Risk of a (SED)
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.

3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment

of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

TCA – Tennessee Code Annotated.

TENNCARE – TENNCARE shall have the same meaning as "State."

TennCare or TennCare Program – The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare's managed care delivery system.

TennCare Medicaid Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in TennCare rules and regulations.

TennCare Select – TennCare Select is a statewide MCO whose risk is backed by the State of Tennessee. TennCare Select was created to serve as a backup if other MCOs failed or there was inadequate MCO capacity and to be the MCO for certain populations, including children in state custody and children eligible for SSI. Children eligible for SSI may opt out of TennCare Select and enroll in another MCO.

TennCare Standard Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver and the TennCare rules and regulations.

TENNderCare – Tennessee's EPSDT program; see EPSDT.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

Tennessee Department of Children's Services (DCS) – The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.

Tennessee Department of Commerce and Insurance (TDCI) – The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

Tennessee Department of Finance and Administration (F&A) – The state agency that oversees all state spending and acts as the chief corporate office of the state. It is the single state Medicaid agency. The Bureau of TennCare is a division of the Tennessee Department of Finance and Administration.

Tennessee Department of Health (DOH) – The state agency having the statutory authority to provide for

health care needs in Tennessee.

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency. DHS is responsible for TennCare eligibility determinations (other than presumptive eligibility and SSI).

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) – The state agency having the authority to provide care for persons with mental illness, substance abuse, and/or developmental disabilities.

Third Party Liability (TPL) – Any amount due for all or part of the cost of medical, behavioral health, or long-term care services from a third party.

Third Party Resource – Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of health care of the enrollee.

Transition Allowance – A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

Unsecured PHI – PHI information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of DHHS.

USC – United States Code.

Vital MCO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be available in Spanish.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Worker – See Consumer-Directed Worker.

2. Section 2.6.1.5.4 shall be amended by adding the acronym "(PERS)" after the reference to "Personal Emergency Response Systems".

3. Section 2.6.1.5.8.1 shall be deleted and replaced as follows:

2.6.1.5.8.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

4. Section 2.6.3.1 shall be amended by deleting the word "alternatives" and replacing it with the words "alternative services".

5. Section 2.7.2.10.2.1 shall be amended by deleting the phrase "seventy-two (72)" and replacing it with the phrase "twenty-four (24)" as follows:

2.7.2.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after twenty-four (24) hours of emergency services, unless there is a court order prohibiting release;

6. Section 2.7.4.2 shall be amended by adding the reference "Section 2.16.2 and" before the reference to "Section 2.17.1".

7. Section 2.7.5.2.2 shall be amended by deleting the word "an" and replacing it with the word "a".

8. Section 2.7.6.2.2.2 shall be amended by deleting the word "EPSDT" and replacing it with the word "TENNderCare".

9. Section 2.7.6.2.10.1.1 and 2.7.6.2.10.2 shall be deleted and replaced as follows:

2.7.6.2.10.1.1 At least thirty percent (30%) shall be conducted in rural areas. Results of the CONTRACTOR's CMS 416 report and HEDIS report, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific populations, particularly members who have limited English proficiency, low literacy levels, behavioral health needs, special health care needs or who are pregnant.

2.7.6.2.10.2 The CONTRACTOR shall contact a minimum of twenty-five (25) state agencies or community-based organizations per quarter, to either educate them on services available through the CONTRACTOR or to develop outreach and educational initiatives. Collaborative activities should include those designed to reach enrollees with limited English proficiency, low literacy levels, behavioral health needs and special health care needs or who are pregnant.

10. Section 2.8.1.1 shall be amended by adding a new Section 2.8.1.1.7 and renumbering the existing Sections accordingly, including any references thereto. The new Section 2.8.1.1.7 shall read as follows:

2.8.1.1.7 Obesity as referenced in Section 2.8.8;

11. Section 2.8.1.4 shall be deleted and replaced as follows:

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

12. Section 2.8.1.4.3 shall be deleted and replaced as follows:

2.8.1.4.3 The guidelines as referenced in Section 2.15.4;

13. Section 2.8.1.4.6 shall be deleted in its entirety and shall be replaced as follows:

2.8.1.4.6 Targeted methods for informing and educating members which, for CHOICES members, include but shall not be limited to mailing educational materials;

14. Section 2.8.1.5 shall be deleted and replaced as follows:

2.8.1.5 As part of its DM program descriptions, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

15. Section 2.8.1.6 shall be deleted and replaced as follows:

2.8.1.6 The CONTRACTOR's DM and care coordination program description shall address how the CONTRACTOR shall ensure that upon enrollment into CHOICES, disease management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care services, including appropriate management of conditions specified in 2.8.1.1. If a CHOICES member has one or more of the conditions specified in Section 2.8.1.1, the member's care coordinator may use the CONTRACTOR's applicable DM tools and resources, including staff with specialized training, to help manage the member's condition and shall integrate the use of these DM tools and resources with care coordination. DM staff shall supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR's program description shall also include at a minimum how the CONTRACTOR will address the following for CHOICES members:

16. Section 2.8.1.6.4 shall be deleted and replaced as follows:

2.8.1.6.4 Ensure that the care coordinator reviews the information noted in Section 2.8.1.6.3 above verbally with the member and with the member's caregiver and/or representative (as applicable) and coordinates any necessary follow-up that may be needed regarding the DM program such as scheduling screenings or appointments;

17. Sections 2.8.1.7 shall be deleted in its entirety.

18. Sections 2.8.7.2 through 2.8.7.2.8 shall be deleted and replaced as follows:

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

2.8.7.2.1 The rate of emergency department utilization and inpatient hospitalization;

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

2.8.7.2.3 Appropriate HEDIS measures;

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

2.8.7.2.5 Member adherence to treatment plans; and

2.8.7.2.6 Provider adherence to the guidelines.

19. Section 2.8.7.3 shall be deleted and the remaining Sections shall be renumbered accordingly, including any references thereto.

20. Section 2.9.1.2.4 shall be deleted in its entirety including all references thereto.

21. Section 2.9.6.1.1 shall be amended by deleting the word "persons" and replacing it with the word "members".

22. Section 2.9.6.2.3.4 shall be amended by adding the phrase "and conduct the level I PASRR screening" to (5)(b) as follows:

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (4) provide information regarding freedom of choice of nursing facility versus HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed by the applicant or his/her representative; (5) for applicants who want to receive NF services (a) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility provider, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (b) provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (6) for applicants who are seeking HCBS: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the applicant regarding the individual cost neutrality cap, and notification to and signed acknowledgement of understanding by the applicant or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the

MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (7) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

23. Section 2.9.6.2.4.9 shall be deleted and replaced as follows:

2.9.6.2.4.9 If the CONTRACTOR is unable to initiate nursing facility services in accordance with the timeframes specified in Section 2.9.6.2.4.4, the CONTRACTOR shall issue written notice to the member, documenting that the service will be delayed, the reasons for the delay, and the date the service will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

24. Section 2.9.6.2.5.9 shall be deleted and replaced as follows:

2.9.6.2.5.9 As part of the face-to-face visit, for members determined to need eligible HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also provide member education regarding choice of contract providers for HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.

25. Section 2.9.6.3.8 shall be amended by deleting the last sentence so that the amended Section 2.9.6.3.8 shall read as follows:

2.9.6.3.8 If, through the screening process described above, or upon other identification by the CONTRACTOR of a member who appears to be eligible for CHOICES for whom the CONTRACTOR opts not to use such screening process, the care coordinator shall conduct a face-to-face intake visit with the member that includes a level of care assessment and a needs assessment (see Section 2.9.6.5) using tool(s) prior approved by TENNCARE and in accordance with the protocols specified by TENNCARE.

26. Section 2.9.6.3.9 shall be amended by adding the phrase "and conduct the level I PASRR screening" to (5)(b) as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator/care coordination team shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in facilitating gathering of categorical/financial documentation needed by DHS; (4) provide information regarding freedom of choice of nursing facility versus HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed by the member or his/her representative; (5) for members who want to receive nursing facility services, (a) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with

respect to payment of patient liability amounts, including the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility provider, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (b) provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (6) for members who are seeking HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the member regarding the individual cost neutrality cap, and notification to and signed acknowledgement of understanding by the member or his/her representative that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; and (7) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

27. Section 2.9.6.3.13.1 shall be amended by deleting the word "and" and replacing it with the word "an".

28. Section 2.9.6.3.14 shall be deleted and replaced as follows:

2.9.6.3.14 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility services if HCBS are not immediately available; (3) determining whether the person wants nursing facility services if HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in Group 2 as a CEA (see Section 2.9.6.3.13.1).

29. Section 2.9.6.3.17.1 shall be deleted and replaced as follows:

2.9.6.3.17.1 For purposes of the CHOICES program, service authorizations for HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. Service authorizations for nursing facility services shall be for the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12) and shall include the duration of nursing facility services to be provided; the

requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR is responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, shall select an alternative provider who is able to initiate services as authorized on or before the requested start date.

30. Section 2.9.6.4.3.2 shall be amended by deleting and replacing the reference "(see Section 2.9.6.2.4.4 and 2.9.6.2.5.3)" with the reference "(see Sections 2.9.6.2.4.4, 2.9.6.2.5.3 and 2.9.6.3.17)".

31. Section 2.9.6.6.1.1 shall be deleted and replaced as follows:

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator/care coordination team may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's file.

32. Section 2.9.6.10 shall be deleted and replaced as follows:

2.9.6.10 Additional Requirements for Care Coordination Regarding Consumer Direction of HCBS

2.9.6.10.1 In addition to the roles and responsibilities otherwise specified in this Section 2.9.6, the CONTRACTOR shall ensure that the following additional care coordination functions related to consumer direction of HCBS are fulfilled.

2.9.6.10.2 The CONTRACTOR shall be responsible for providing all needed eligible HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.6.10.3 If a member is interested in participating in consumer direction of HCBS and the member does not intend to appoint a representative, the care coordinator shall determine the extent to which the member may require assistance to direct his/her services (see Section 2.9.7.4.5). If the care coordinator determines that the member requires assistance to direct his/her services, based upon the results of a completed self-assessment instrument developed by TENNCARE, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf (see Section 2.9.7.4.5.1).

2.9.6.10.4 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1) and that a representative agreement is completed and signed by the member prior to forwarding a referral to the FEA (see Section 2.9.7.4.7).

2.9.6.10.5 For members electing to participate in consumer direction, forward to the FEA a referral initiating the member's participation in consumer direction of HCBS: (1) within two (2) business days of signing the representative agreement; or (2) if a representative is not designated by the member, within two (2) business days of completion of the self-assessment instrument and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care.

2.9.6.10.6 For members electing to participate in consumer direction, the member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.

2.9.6.10.7 For members electing to participate in consumer direction, the member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in consumer- directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care

2.9.6.10.8 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, as applicable, shall be signed by the care coordinator and the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

2.9.6.10.9 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that, for members participating in consumer direction, the member's supports broker is invited to participate in these meetings.

2.9.6.10.10 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for consumer directed services shall include authorized service, authorized units of service, including amount, frequency and

duration and the schedule at which services are needed, start and end dates, and service code(s).

2.9.6.10.11 The member's care coordinator/care coordination team shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction of HCBS (see Section 2.9.7.3.4).

2.9.6.10.12 The CONTRACTOR shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.

2.9.6.10.13 The care coordinator shall determine a member's interest in enrolling in or continuing to participate in consumer direction annually and shall document the member's decision in the member's plan of care.

2.9.6.10.14 If at anytime abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative and/or worker shall no longer be allowed to participate in the CHOICES program in any capacity. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

33. Section 2.9.6.12.3.1 shall be amended by inserting "an" before "individual" and deleting the text "consumer direction" before the word "worker".

34. Section 2.9.6.12.3.10 shall be deleted and replaced as follows:

2.9.6.12.3.10 The CONTRACTOR shall ensure that the EVV system creates and makes available to providers and to the FEA on at least a daily basis an electronic claims submission file in the 837 format, including exceptions which have been resolved, which may be submitted to the CONTRACTOR for claims processing at the appropriate frequency.

35. Section 2.9.6.12.3.11 shall be deleted in its entirety.

36. Section 2.9.7 shall be deleted and replaced as follows:

2.9.7 Consumer Direction of HCBS

2.9.7.1 General

2.9.7.1.1 The CONTRACTOR shall offer consumer direction of HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, homemaker, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons electing consumer direction of HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible HCBS or to withdraw from participation in consumer direction of HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of HCBS.

2.9.7.1.2 Consumer direction is a process by which eligible HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Care rather than the TennCare Solutions Units, which manages medical appeals pertaining to TennCare benefits (i.e., services).

2.9.7.1.3 Members who participate in consumer direction of HCBS choose either to serve as the employer of record of their workers or to designate a representative (see definition below in Section 2.9.7.2.1) to serve as the employer of record on his/her behalf. As the employer of record the member or his/her representative is responsible for the following:

2.9.7.1.3.1 Recruiting, hiring and firing workers;

2.9.7.1.3.2 Determining workers' duties and developing job descriptions;

2.9.7.1.3.3 Scheduling workers;

2.9.7.1.3.4 Supervising workers;

2.9.7.1.3.5 Evaluating worker performance and addressing any identified deficiencies or concerns;

2.9.7.1.3.6 Setting wages up to a specified maximum amount established by TENNCARE;

2.9.7.1.3.7 Training workers to provide personalized care based on the member's needs and preferences;

2.9.7.1.3.8 Ensuring that workers deliver only those services authorized, and reviewing and approving hours worked by consumer-directed workers;

2.9.7.1.3.9 Reviewing and ensuring proper documentation for services provided; and

2.9.7.1.3.10 Developing and implementing as needed a back-up plan to address instances when a scheduled worker is not available or fails to show up as scheduled.

2.9.7.2 Representative

2.9.7.2.1 A member may designate, or have appointed by a guardian, a representative to assume the consumer direction responsibilities on his/her behalf. A representative shall meet, at minimum the following requirements: be at least 18 years of age, have a personal relationship with the member and understand his/her support needs; knows the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker.

2.9.7.2.2 In order to participate in consumer direction of HCBS with the assistance of a representative, one of the following must apply: (1) the member must have the ability to designate a person to serve as his/her representative or (2) the member has a legally appointed representative who may serve as the member's representative.

2.9.7.2.3 The care coordinator shall, based on a self-assessment completed by the member, determine if the member requires assistance in carrying out the responsibilities required for consumer direction and therefore requires a representative. The member's care coordinator/care coordination team shall verify that a representative meets the qualifications as described in Section 2.9.7.2.1 above.

2.9.7.2.4 A member's representative shall not receive payment for serving in this capacity and shall not serve as the member's worker for any consumer directed service. The CONTRACTOR shall use a representative agreement developed by TENNCARE to document a member's choice of a representative for consumer direction of HCBS and the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The CONTRACTOR shall notify the FEA within three (3) business days when it becomes aware of any changes to a representative's contact information.

2.9.7.2.5 The representative agreement shall be signed by the member (or person authorized to sign on member's behalf) and the representative in the presence of the care coordinator. The care coordinator shall include the representative agreement in the member's file and provide copies to the member and/or the member's representative and the FEA.

2.9.7.2.6 A member may change his/her representative at any time. The member shall immediately notify his/her care coordinator and his/her supports broker when he/she intends to change representatives. The care coordinator shall verify that the new representative meets the qualifications as described above. A new representative agreement shall be completed and signed, in the presence of a care coordinator, prior to the new representative assuming their respective responsibilities. The care coordinator shall immediately notify the FEA in writing when a member changes his/her representative and provide a copy of the representative agreement. The CONTRACTOR shall facilitate a seamless transition to the new representative, and ensure that there are no interruptions or gaps in services. As part of the needs assessment and plan of care process, the care coordinator shall educate the member about the importance of notifying the care coordinator prior to changing a representative.

2.9.7.2.7 The FEA shall ensure that the new representative signs all service agreements (see Section 2.9.7.6.6).

2.9.7.3 <u>Fiscal Employer Agent (FEA)</u>

2.9.7.3.1 The CONTRACTOR shall enter into a contract with the FEA specified by TENNCARE to provide assistance to members choosing consumer direction.

2.9.7.3.2 The FEA shall fulfill, at a minimum, the following financial administration and supports brokerage functions, as specified in the CONTRACTOR's contract with the FEA and the FEA's contract with TENNCARE, for all CHOICES members electing consumer direction of HCBS:

2.9.7.3.2.1 Assign a supports broker to each CHOICES member electing to participate in consumer direction of HCBS;

2.9.7.3.2.2 Assist in identifying and addressing in the risk assessment and plan of care processes any additional risk associated with the member participating in consumer direction;

2.9.7.3.2.3 Provide initial and ongoing training to members and their representatives (as applicable) on consumer direction and other relevant issues (see Section 2.9.7.7 of this Agreement);

2.9.7.3.2.4 Verify worker qualifications, including, as specified by TENNCARE, conduct background checks on workers, enroll workers into Medicaid, assign provider Medicaid ID numbers, and hold Medicaid provider agreements (see Section 2.9.7.6.1 of this Agreement);

2.9.7.3.2.5 Provide initial and ongoing training to workers on consumer direction and other relevant issues (see Section 2.9.7.7 of this Agreement);

2.9.7.3.2.6 Assist the member and/or representative in developing and updating service agreements (see Section 2.9.7.6.6);

2.9.7.3.2.7 Receive, review and process electronically captured visit information;

2.9.7.3.2.8 Resolve discrepancies regarding electronically captured visit information;

2.9.7.3.2.9 Obtain documentation from the member and/or representative to ensure that services were provided prior to payment of workers;

2.9.7.3.2.10 Withhold, file and pay applicable: federal, state and local income taxes; employment and unemployment taxes; and worker's compensation;

2.9.7.3.2.11 Pay workers for authorized services rendered within authorized timeframes;

2.9.7.3.2.12 Facilitate resolution of any disputes regarding payment to workers for services rendered;

2.9.7.3.2.13 Monitor quality of services provided by workers; and

2.9.7.3.2.14 Report to the CONTRACTOR on worker and/or staff identification of, response to, participation in and/or investigation of critical incidents (see Section 2.15.8).

2.9.7.3.3 The FEA shall also fulfill, at a minimum, the following financial administration and supports brokerage functions for CHOICES members electing consumer direction of HCBS on an as needed basis:

2.9.7.3.3.1 Assist the member and/or representative in developing job descriptions;

2.9.7.3.3.2 Assist the member and/or representative in locating and recruiting workers;

2.9.7.3.3.3 Assist the member and/or representative in interviewing workers (developing questions, evaluating responses);

2.9.7.3.3.4 Assist the member and/or representative in scheduling workers;

2.9.7.3.3.5 Assist the member and/or representative in managing and monitoring payments to workers; and

2.9.7.3.3.6 Assist the member and/or representative in monitoring and evaluating the performance of workers.

2.9.7.3.4 The CONTRACTOR's care coordination functions shall not duplicate the supports brokerage functions performed by the FEA or its subcontractor. A member's care coordinator shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction.

2.9.7.3.5 The CONTRACTOR's contract with the FEA shall include the provisions specified by TENNCARE in the model CONTRACTOR-FEA contract.

2.9.7.3.6 The CONTRACTOR in collaboration with the FEA shall establish a process that allows for the efficient exchange of all relevant member information regarding members electing to participate in consumer direction between the CONTRACTOR and the FEA.

2.9.7.3.7 The CONTRACTOR and FEA shall develop a protocol for interfaces and transfers of customer service inquiries per the requirements of Section 2.18 of this Agreement.

2.9.7.3.8 The CONTRACTOR shall provide to the FEA copies of all relevant initial and updated member documents, including at a minimum, plans of care, representative agreements and risk agreements. The CONTRACTOR shall provide to the FEA all relevant documentation prior to service delivery.

2.9.7.3.9 The CONTRACTOR shall require that the EVV system: (1) provide functionality and access to the FEA for purposes of scheduling workers who will deliver services in accordance with the schedule determined by the CONTRACTOR and for monitoring service delivery; and (2) facilitate access by the FEA to electronically captured visit information in order to process exceptions, to process payroll for workers, and for purposes of claims submission to the CONTRACTOR once exceptions have been resolved.

2.9.7.3.10 The FEA shall screen monthly to determine if workers have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. If a worker has been excluded, the FEA shall notify the member regarding the worker's status and work with the member to find a replacement worker. The FEA shall notify the CONTRACTOR regarding the worker status. The CONTRACTOR shall work with the member to obtain a replacement contract provider until a replacement worker can be found and all worker requirements are fulfilled and verified.

2.9.7.3.11 *FEA Training*

2.9.7.3.11.1 The CONTRACTOR shall provide education and training to the FEA and its staff and subcontracted supports brokers (as applicable) regarding key requirements of this Agreement and the contract between the CONTRACTOR and the FEA.

2.9.7.3.11.2 The CONTRACTOR shall provide to the FEA, in electronic format (including but not limited to CD or access via a web link), a member handbook and updates thereafter annually or any time material changes are made.

2.9.7.3.11.3 The CONTRACTOR shall conduct initial education and training to the FEA and its staff at least thirty (30) days prior to implementation of CHOICES in the Grand Region covered by this Agreement. This education and training shall include, but not be limited to, the following:

2.9.7.3.11.3.1 The role and responsibilities of the care coordinator, including as it relates to members electing to participate in consumer direction;

2.9.7.3.11.3.2 CHOICES needs assessment and care planning development, implementation, and monitoring processes, including the development and activation of a back-up plan for members participating in consumer direction;

2.9.7.3.11.3.3 The FEA's responsibilities for communicating with the CONTRACTOR, members, representatives and workers and TENNCARE, and the process by which to do this;

2.9.7.3.11.3.4 Customer service requirements;

2.9.7.3.11.3.5 Requirements and processes regarding referral to the FEA;

2.9.7.3.11.3.6 Requirements and processes, including timeframes for authorization of consumer directed HCBS;

2.9.7.3.11.3.7 Requirements and processes, including timeframes, for claims submission and payment and coding requirements;

2.9.7.3.11.3.8 Systems requirements and information exchange requirements;

2.9.7.3.11.3.9 Requirements regarding the EVV system;

2.9.7.3.11.3.10 Requirements and role and responsibility regarding abuse and neglect plan protocols, and critical incident reporting and management;

2.9.7.3.11.3.11 The FEA's role and responsibility in implementing the CONTRACTOR's fraud and abuse plan;

2.9.7.3.11.3.12 CHOICES program quality requirements; and

2.9.7.3.11.3.13 The CONTRACTOR's member complaint and appeal processes.

2.9.7.3.11.4 The CONTRACTOR shall provide ongoing FEA education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement and the contract between the CONTRACTOR and the FEA.

2.9.7.3.11.5 The CONTRACTOR shall require the Electronic Visit Verification (EVV) vendor to provide training to the FEA and its supports brokers regarding the EVV system, and a training curriculum that shall be utilized by the FEA in training consumer-directed workers.

2.9.7.3.11.6 The FEA shall provide training to the CONTRACTOR's care coordinators regarding consumer direction of HCBS and the role and responsibilities of the FEA (including financial administration and supports brokerage functions)

2.9.7.4 <u>Needs Assessment/Plan of Care Process</u>

2.9.7.4.1 A CHOICES member may choose to direct needed eligible HCBS at anytime: during CHOICES intake, through the needs assessment/reassessment and plan of care and plan of care update processes; and outside of these processes. The care coordinator shall assess the

member's needs for eligible HCBS per requirements in Sections 2.9.6.2.4, 2.9.6.3 and 2.9.6.5, as applicable. The care coordinator shall use the plan of care process (including updates) to identify the eligible services that the member will direct and to facilitate the member's enrollment in consumer direction of HCBS.

2.9.7.4.2 The CONTRACTOR shall obtain from the member a signed statement regarding the member's decision to participate in consumer direction of HCBS.

2.9.7.4.2.1 The care coordinator shall assist the member in identifying which of the needed eligible HCBS shall be consumer directed, provided by contract providers or a combination of both, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.3 If the member intends to direct one or more needed eligible HCBS, throughout the period of time that consumer direction is being initiated, the CONTRACTOR shall arrange for the provision of needed HCBS through contract providers in accordance with 2.9.6. The care coordinator shall obtain from the member his/her choice of contract providers who will provide HCBS until such time as workers are secured and ready to begin delivering care through consumer direction.

2.9.7.4.3.1 If a member has been assessed to need companion care services, the CONTRACTOR shall identify non-residential services that will offer interim support to address the member's needs and assist the member in obtaining contract providers for these services.

2.9.7.4.4 The CONTRACTOR shall be responsible for providing all needed eligible HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of HCBS, based upon the results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member's file.

2.9.7.4.5.1 If, based on the results of the self-assessment the care coordinator determines that a member requires assistance to direct his/her services, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf.

2.9.7.4.5.2 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to deny participation in consumer direction because a care coordinator has determined that the health, safety and welfare of the member would be in jeopardy if the member participates in consumer direction without a representative but the member does not want to appoint a representative to assist in directing his/her services. The CONTRACTOR shall abide by TENNCARE's decision.

2.9.7.4.6 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1 of this Agreement) and that a representative agreement is completed and signed by the member and the person prior to forwarding a referral to the FEA (see Section 2.9.7.4.7 below).

2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each by type; and care coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of HCBS. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.

2.9.7.4.8 Within two (2) business days of receipt of the referral, the FEA shall assign a supports broker to the member, notify the care coordinator of the assignment and provide the name and contact information of the supports broker.

2.9.7.4.9 Within five (5) days of receipt of the referral, the FEA shall contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating consumer direction of HCBS.

2.9.7.4.10 *Back-up Plan for Consumer Direction and Updated Risk Assessment/Risk Agreement*

2.9.7.4.10.1 The FEA shall assist the member/representative as needed in developing a back-up plan for consumer direction that adequately identifies how the member/representative will address situations when a scheduled worker is not available or fails to show up as scheduled. The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services.

2.9.7.4.10.2 The member/representative (as applicable) may not elect, as part of the back-up plan, to go without services.

2.9.7.4.10.3 The back-up plan for consumer direction shall include the names and telephone numbers of contacts (workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. The FEA shall confirm with these persons and/or organizations to confirm their willingness and availability to provide care when needed, document confirmation in the member's file and forward a copy of the documentation to the CONTRACTOR.

2.9.7.4.10.5 The member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.

2.9.7.4.10.6 The FEA shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to address the member's needs, and notify the care coordinator immediately regarding any concerns with the back-up plan or the member's care.

2.9.7.4.10.7 The FEA shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the FEA shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the member's care coordinator.

2.9.7.4.10.8 The FEA and the CONTRACTOR shall each file a copy of the back-up plan for consumer direction in the member's file.

2.9.7.4.10.9 The member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also

serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

2.9.7.4.10.10 The CONTRACTOR shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. Once a referral has been made to the FEA for consumer direction, the member's supports broker should be involved in risk assessment and risk planning activities whenever possible. The new or updated risk agreement, as applicable, shall be signed by the care coordinator and the member or his/her representative (as applicable). The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file.

2.9.7.4.10.11 The FEA shall notify the member's care coordinator immediately when there are changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk, or changes to the plan of care or risk agreement.

2.9.7.4.10.12 The FEA shall assist the CONTRACTOR in identifying and addressing in the risk assessment and plan of care processes any additional risk associated with the member participating in consumer direction.

2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the member's supports broker is invited to participate in these meetings.

2.9.7.5 <u>Authorizations for Consumer Directed Services and Service Initiation</u>

2.9.7.5.1 Consumer direction of HCBS shall not be initiated until all requirements are fulfilled including but not limited to the following: (1) the FEA verifies that the member's employer and related documentation is in order; (2) the FEA verifies that workers meet all qualifications, including participation in required training; (3) there is a signed service agreement specific to each individual worker (see Section 2.9.7.6.6 of this Agreement); and (4) the CONTRACTOR issues to the FEA an authorization for consumer directed services (see 2.9.7.5.6 below) for each service.

2.9.7.5.2 The FEA shall work with the member to determine the appropriate level of assistance necessary to recruit, interview and hire workers and provide the assistance.

2.9.7.5.3 Once potential workers are identified, the FEA shall verify that a potential worker meets all applicable qualifications (see Section 2.9.7.6.1 of this Agreement).

2.9.7.5.4 The FEA shall ensure that a service agreement is signed between the member or member's representative and his/her worker within five (5) business days following the FEA's verification that a worker meets all qualifications.

2.9.7.5.5 The FEA shall periodically update the member's care coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

2.9.7.5.6 The provision of consumer directed services shall begin as soon as possible but no longer than sixty (60) days from the date of the CONTRACTOR's referral to the FEA, except due to circumstances beyond the control of the FEA. Prior to beginning the provision of consumer directed services, the FEA shall notify the CONTRACTOR that all requirements have been fulfilled, including verification of all worker qualifications, criminal background checks, signed service agreements, and that the member is ready to begin consumer direction of HCBS. Within two (2) business days of receipt of the notification from the FEA, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services. Each authorization for consumer directed services shall include authorized service; authorized units of service, including amount, frequency and duration and the schedule at which services are needed; start and end dates; and service code(s). Authorized units of service in a service authorization should reflect the units of measure specified by TENNCARE for the benefit (e.g. visits, hours, days). The CONTRACTOR shall submit authorizations electronically on at least a daily basis using the agreed upon data interface (which may include a standard electronic file transfer, the FEA's web portal technology, the EVV system, or any combination thereof).

2.9.7.5.7 If initiation of consumer directed services does not begin within sixty (60) days from the date of the CONTRACTOR's referral to the FEA, the FEA shall contact the CONTRACTOR regarding the cause of the delay and provide appropriate documentation to demonstrate efforts to meet the timeframe. The CONTRACTOR shall determine the appropriate next steps, including but not limited to whether additional time is needed or if the member is still interested in participating in consumer direction of HCBS.

2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall contact the FEA who shall assist the member or his/her representative as needed in implementing the member's back-up plan for consumer direction.

2.9.7.5.9 Within five (5) business days of the scheduled start date of consumer directed services as specified in the authorization of consumer directed services, a member of the care coordinator team shall contact the member or his/her representative to confirm that services are being provided and that the member's needs are being met.

2.9.7.5.10 On an ongoing basis, in addition to requirements specified above in 2.9.7.5.3 – 2.9.7.5.9 above:

2.9.7.5.10.1 The CONTRACTOR shall develop and forward to the FEA a new authorization for consumer directed services when the following occur: a change in the number of service

units, or the frequency or duration of service delivery, or a change in the schedule at which services are needed; or a change in the services to be provided through consumer direction, including the provision of a new service through consumer direction or termination of a service through consumer direction.

2.9.7.6 Worker Qualifications

2.9.7.6.1 As prescribed in the FEA's contract with TENNCARE, the FEA shall ensure that workers meet all requirements prior to the worker providing services. The FEA shall ensure that workers: meet all TennCare established requirements for providers of comparable, non-consumer directed services; pass a background check which includes criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company, verification that the person's name does not appear on the State abuse registry, verification that the person's name does not appear on the state and national sexual offender registries and licensure verification, as applicable; complete all required training, including the training specified in Section 2.9.7.7 of this Agreement; complete all required applications to become a TennCare provider; sign an abbreviated Medicaid agreement; are assigned a Medicaid provider ID number; and sign a service agreement.

2.9.7.6.1.1 A member cannot waive a background check for a potential worker. The following findings shall disqualify a person from serving as a worker:

2.9.7.6.1.1.1 Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug;

2.9.7.6.1.1.2 Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held;

2.9.7.6.1.1.3 Identification on the abuse registry;

2.9.7.6.1.1.4 Identification on the state or national sexual offender registry;

2.9.7.6.1.1.5 Failure to have a required license; and

2.9.7.6.1.1.6 Refusal to cooperate with a background check.

2.9.7.6.1.2 If a worker fails the background check, the FEA shall make the decision regarding exceptions to disqualification in accordance with TennCare policy. In the event a member chooses to hire a worker that has failed a background check but has met all of the conditions for an exception to disqualification, as prescribed by TennCare, and the FEA has granted the exception, the FEA shall notify the member's care coordinator prior to initiation of services provided by that worker. Exceptions to disqualification may be granted at the member's discretion and only if all of the following conditions are met:

2.9.7.6.1.2.1 Offense is a misdemeanor;

2.9.7.6.1.2.2 Offense occurred more than five (5) years ago;

2.9.7.6.1.2.3 Offense is not related to physical or sexual or emotional abuse of another person;

2.9.7.6.1.2.4 Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and

2.9.7.6.1.2.5 There is only one disqualifying offense.

2.9.7.6.2 Workers are not required to be contract providers. The CONTRACTOR shall not require a worker to sign a provider agreement or any other agreement not specified by TENNCARE.

2.9.7.6.3 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as a worker, such as a neighbor or a friend.

2.9.7.6.4 Members may hire family members, excluding spouses, to serve as a worker. A family member shall not be reimbursed for a service that he/she would have otherwise provided without pay. The CONTRACTOR shall use the needs assessment process (see Section 2.9.6.5) to assess the member's available existing supports, including supports provided by family members.

2.9.7.6.5 A member may have multiple workers or both a worker and a contract provider for a given service, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. A member may elect to have a worker provide more than one service.

2.9.7.6.6 A member shall develop a service agreement with each worker. The service agreement template shall be developed by TENNCARE and shall include, at a minimum: the roles and responsibilities of the worker and the member; the worker's schedule (as developed by the member and/or representative), including hours and days; the scope of each service, i.e., the specific tasks and functions the worker is to perform; the service rate; and the requested start date for services. The service agreement shall serve as the worker's written confirmation of his/her commitment to initiate services on or before the date specified and to provide services in accordance with specified terms (including the tasks and functions to be performed and the schedule at which care is needed). If necessary, the FEA shall assist in this process. Service agreements shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Service agreements shall be signed by the new representative when there is a change in representatives.

2.9.7.6.7 The service agreement shall also stipulate if a worker will provide one or more self-directed health care tasks, the specific task(s) to be performed, and the frequency of each self-directed health care task (see Section 2.7 3).

2.9.7.6.8 The FEA shall ensure that a service agreement is in place for each worker prior to the worker providing services.

2.9.7.6.9 A copy of each service agreement shall be provided to the member and/or representative. The FEA shall give a copy of the service agreement to the worker and shall maintain a copy for its files.

2.9.7.6.10 A member may terminate a worker at any time if he/she feels that the worker is not adhering to the terms of the service agreement and/or is not providing quality services. If the FEA or care coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the plan of care, but the member and/or representative chooses to continue to employ the worker, the care coordinator shall note the concern and the member's choice to continue using the worker in the member's plan of care, and shall update the risk assessment and/or risk agreement as needed. The FEA and care coordinator shall collaborate to develop strategies to address identified issues and concerns. The FEA shall inform the member and/or representative of any potential risks associated with continuing to use the worker. The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll the member from consumer direction because a care coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker. The CONTRACTOR and FEA shall abide by TENNCARE's decision.

2.9.7.6.11 A member shall have the flexibility to choose from a range of TENNCARE specified reimbursement levels for all eligible consumer directed HCBS, excluding companion care services which shall be reimbursed at the rate specified by TENNCARE.

2.9.7.6.12 In order to receive payment for services rendered, all workers must:

2.9.7.6.12.1 Deliver services in accordance with the schedule of services specified in the member's plan of care and in the MCO's service authorization, and in accordance with worker assignments determined by the member or his/her representative. The FEA shall input the member/representative's assignment of individual workers into the EVV; and

2.9.7.6.12.2 Maintain and submit documentation of service delivery (i.e., documentation of the tasks and functions performed during the provision of services), and any other documentation, as required, for units of service delivered; and

2.9.7.6.12.3 Provide no more than forty (40) hours of services within a consecutive seven (7) day period, unless explicitly permitted by program guidelines and in accordance with service authorizations.

2.9.7.6.13 The FEA shall enter worker schedules into the EVV system in accordance with the CONTRACTOR's guidelines and the schedule at which services are needed by the member, based on the member's plan of care and the CONTRACTOR's service authorization.

2.9.7.7 <u>Training</u>

2.9.7.7.1 The CONTRACTOR shall require all members electing to enroll in consumer direction of HCBS and/or their representatives to receive relevant training. The FEA shall be responsible for providing or arranging for initial and ongoing training of members/representatives. When training is not directly provided by the FEA, the FEA shall validate completion of training. Initial training shall be completed prior to initiation of consumer-directed services.

2.9.7.7.2 At a minimum, consumer direction training for members and/or representatives shall address the following issues:

2.9.7.7.2.1 Understanding the role of members and representatives in consumer direction;

2.9.7.7.2.2 Understanding the role of the care coordinator and the FEA;

2.9.7.7.2.3 Selecting workers;

2.9.7.7.2.4 Abuse and neglect prevention and reporting;

2.9.7.7.2.5 Being an employer, evaluating worker performance and managing workers;

2.9.7.7.2.6 Fraud and abuse prevention and reporting;

2.9.7.7.2.7 Performing administrative tasks such as reviewing and approving electronically captured visit information; and

2.9.7.7.2.8 Scheduling workers and back-up planning.

2.9.7.7.3 Ongoing training shall be provided by the FEA to members and/or representatives upon request and/or if a care coordinator or FEA, through monitoring, determines that additional training is warranted.

2.9.7.7.4 The FEA shall be responsible for providing or arranging for initial and ongoing training of all workers. When training is not directly provided by the FEA, the FEA shall validate completion of training. Initial training shall be completed prior to initiation of services. At a minimum, training shall consist of the following required elements:

2.9.7.7.4.1 Overview of the CHOICES program and consumer direction of HCBS;

2.9.7.7.4.2 Caring for elderly and disabled populations;

2.9.7.7.4.3 Abuse and neglect identification and reporting;

2.9.7.7.4.4 CPR and first aid certification;

2.9.7.7.4.5 Critical incident reporting;

2.9.7.7.4.6 Submission of required documentation and withholdings;

2.9.7.7.4.7 Use of the EVV system; and

2.9.7.7.4.8 As appropriate, administration of self-directed health care task(s).

2.9.7.7.5 The FEA shall assist the member/representative in determining to what extent the member/representative shall be involved in the above-specified training. The member/ representative) shall provide additional training to the worker regarding individualized service needs and preference.

2.9.7.7.6 The FEA shall verify that workers have successfully completed all required training prior to service initiation and payment for services.

2.9.7.7.7 Ongoing, the FEA shall ensure that workers maintain CPR and first aid certification and receive required refresher training as a condition of continued employment and shall arrange for the appropriate training. Additional training components may be provided to a worker to address issues identified by the FEA, care coordinator, member and/or the representative or at the request of the worker.

2.9.7.7.8 Refresher training may be provided more frequently if determined necessary by the FEA, care coordinator, member and/or representative or at the request of the worker.

2.9.7.8 Monitoring

2.9.7.8.1 The CONTRACTOR shall monitor the quality of service delivery and the health, safety and welfare of members participating in consumer direction through the CHOICES care coordination functions.

2.9.7.8.2 The CONTRACTOR shall monitor for late or missed visits by consumer-directed workers.

2.9.7.8.3 The CONTRACTOR shall require that the EVV system include functionality to provide prompt (i.e., "real time") notification 24 hours/day, 7 days/week via automated email, as defined in business rules, to the MCO and to the FEA if a consumer directed worker does not arrive as scheduled, or otherwise deviates from the authorized schedule so that gaps in care are immediately identified and addressed. Alerts will be provided via email, the monitoring alert dashboard, and text messaging.

2.9.7.8.4 The CONTRACTOR shall monitor implementation of the back-up plan by the member or his/her representative, with assistance provided to the member/representative by the FEA Supports Broker as needed.

2.9.7.8.5 The CONTRACTOR shall monitor a member's participation in consumer direction of HCBS to determine, at a minimum, the success and the viability of the service delivery model for the member. The CONTRACTOR shall note any patterns, such as frequent turnover of representatives and changing between consumer direction of HCBS and contract providers that may warrant intervention by the CONTRACTOR. The CONTRACTOR may submit a request to TENNCARE, pursuant to TennCare policy, to involuntarily withdraw the member from consumer direction of HCBS if the CONTRACTOR has concerns about its ability to protect the health, safety and welfare of the member (see Section 2.9.7.9.4).

2.9.7.8.6 If at any time abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols developed by the CONTRACTOR. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative and/or worker shall no longer be allowed to participate in the CHOICES

program in any capacity. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

2.9.7.9 Withdrawal from Consumer Direction of HCBS

2.9.7.9.1 A member may voluntarily withdraw from consumer direction of HCBS at any time. The member and/or representative shall notify the care coordinator as soon as he/she determines that he/she is no longer interested in participating in consumer direction of HCBS.

2.9.7.9.2 Upon receipt of a member's request to withdraw from consumer direction of HCBS, the CONTRACTOR shall conduct a face-to-face visit and update the member's plan of care, as appropriate, to initiate the process to transition the member to contract providers.

2.9.7.9.3 In the event that the FEA or care coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the plan of care, but the member and/or representative chooses to continue to employ the worker, note the concern and the member's choice to continue using the worker in the member's plan of care, and shall update the risk assessment and/or risk agreement as needed.

2.9.7.9.4 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll a member from consumer direction. The CONTRACTOR may initiate involuntary withdrawal of a member from consumer direction of HCBS:

2.9.7.9.4.1 If a member's representative fails to perform in accordance with the terms of the representative agreement and the health, safety and welfare of the member is at risk, and the member wants to continue to use the representative.

2.9.7.9.4.2 If a member has consistently demonstrated that he/she is unable to manage, with sufficient supports (including appointment of a representative) his/her services and the care coordinator or FEA has identified health, safety and/or welfare issues.

2.9.7.9.4.3 A care coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker.

2.9.7.9.4.4 Other significant concerns regarding the member's participation in consumer direction which jeopardize the health, safety or welfare of the member.

2.9.7.9.5 If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).

2.9.7.9.6 The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition from workers to contract providers and ensure there are no interruptions or gaps in services.

2.9.7.9.7 Voluntary or involuntary withdrawal of a member from consumer direction of HCBS shall not affect a member's eligibility for long-term care services or enrollment in CHOICES.

2.9.7.9.8 The CONTRACTOR shall notify the FEA within one business day of processing the enrollment file when a member voluntarily withdraws from consumer direction of HCBS, when a member is involuntarily withdrawn from consumer direction of HCBS, and when a member is disenrolled from CHOICES or from TennCare. The notification should include the effective date of withdrawal and/or disenrollment, as applicable.

2.9.7.9.9 Members who have been involuntarily withdrawn may request to be reinstated in consumer direction of HCBS. The care coordinator shall work with the FEA to ensure that the issues previously identified as reasons for withdrawal have been adequately addressed prior to reinstatement. All members shall be required to participate in consumer direction training programs prior to re-instatement in consumer direction of HCBS.

2.9.7.9.10 <u>Claims Submission and Payment</u>

2.9.7.9.10.1 The CONTRACTOR shall ensure that the EVV system creates and makes available to the FEA on at least a daily basis an electronic claims submission file in the 837 format, including exceptions which have been resolved, which may be submitted to the CONTRACTOR for claims processing at the appropriate frequency.

2.9.7.9.10.2 The CONTRACTOR shall reimburse the FEA for authorized HCBS provided by workers at the appropriate rate for the consumer-directed services, which includes applicable payroll taxes.

2.9.7.9.10.3 The CONTRACTOR shall process and pay claims submitted by the FEA within fourteen (14) calendar days of receipt.

37. Section 2.9.8.1 shall be deleted and replaced as follows:

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

management, care coordination (for CHOICES members) and disease management, provider training, and monitoring implementation and outcomes.

38. The second sentence in Section 2.9.8.2 shall be amended by deleting the reference "2.9.8.2" and replacing it with the reference "2.9.8.1".

39. Section 2.9.14 shall be deleted and replaced in its entirety.

2.9.14 **Inter-Agency Coordination**

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

2.9.14.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;

2.9.14.2 Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care;

2.9.14.3 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;

2.9.14.4 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;

2.9.14.5 The Division of Intellectual Disabilities Services (DIDS), for the purposes of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;

2.9.14.6 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TennCare and CHOICES, assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process, and facilitating the transition of members during CHOICES implementation and when members are moving to a Grand Region where CHOICES has not yet been implemented;

2.9.14.7 Tennessee Commission on Aging and Disability (TCAD) regarding TCAD's role in monitoring the performance of the AAADs in conducting SPOE functions;

2.9.14.8 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.14.8.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental

consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system.

2.9.14.8.2 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the CONTRACTOR shall:

2.9.14.8.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.

2.9.14.8.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.14.8.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within 14 days of the CONTRACTOR's receipt of the IEP.

2.9.14.9 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

40. Section 2.12.9.26 shall be amended by adding a new sentence to the end of the Section as follows:

2.12.9.26 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR. However, the agreement shall not include rate methodology that provides for an automatic increase in rates;

41. Section 2.13.1.1 shall be amended by adding a new second sentence as follows:

2.13.1.1 The CONTRACTOR shall agree to reasonable reimbursement standards to providers for covered services, to be determined in conjunction with actuarially sound rate setting. The CONTRACTOR shall not agree to reimbursement rate methodology that provides for an automatic increase in rates. All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

42. Section 2.13.3.3 shall be deleted and replaced as follows:

2.13.3.3 If, prior to the end date specified by TENNCARE in its approval of Level II nursing facility services, the CONTRACTOR determines that the nursing facility is providing Level I and not Level II nursing facility services, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the

request. Upon approval from TENNCARE, the CONTRACTOR may adjust payment to the nursing facility to reflect the level of nursing facility services actually provided to the member and shall maintain documentation as specified by TENNCARE to support the payment adjustment.

43. Section 2.13.20 shall be amended by deleting the word "subcontract" and replacing it with the word "contract" and deleting the reference to "Section 2.26.6".

44. Section 2.14.1.3 shall be amended by deleting the word "network" and replacing it with the word "contract".

45. Section 2.14.1.7 shall be amended by deleting the reference to "Section 2.6.1.3" and replacing it with a reference to "Section 2.6.1.4".

46. Section 2.14.4.5 shall be amended by deleting the references to "Section 2.9.2.1" and replacing them with the references "Section 2.9.2".

47. Section 2.15.1.1 shall be deleted and replaced as follows:

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

48. Section 2.15.1.4 shall be deleted and replaced as follows:

2.15.1.4 Any changes to the QM/QI program structure, including that of CHOICES, shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements. All three of these documents shall include CHOICES information.

49. Section 2.15.3.1.2 shall be deleted and replaced as follows:

2.15.3.1.2 Two (2) of the three (3) non-clinical PIPs shall be in the area of long-term care. The CONTRACTOR shall use existing processes, methodologies, and protocols, including the CMS protocols.

50. Section 2.15.4 shall be deleted and replaced as follows:

2.15.4 **Clinical Practice Guidelines**

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs. The guidelines shall be reviewed and revised at least every two (2) years or whenever the guidelines change.

51. Section 2.15.6.1 and 2.15.6.2 shall be deleted and replaced as follows:

2.15.6.1 Annually, beginning with HEDIS 2009, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The HEDIS measure results shall be reported separately for each Grand Region in which the CONTRACTOR operates. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

2.15.6.2 Annually, beginning in 2009, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. The survey results shall be reported separately for each Grand Region in which the CONTRACTOR operates. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

52. Section 2.15.7 shall be deleted in its entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

53. The renumbered Sections 2.15.7.4.6 and 2.15.7.4.7 shall be deleted and replaced as follows:

2.15.7.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in a accordance with Section 2.15.8.4.1, investigating critical incidents, submitting a report on investigations to the CONTRACTOR and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section 2.9.7.8.6); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.8.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.15.7.4.7 Reviewing the FEA's reports and investigations regarding critical incidents and follow-up with the FEA as necessary regarding corrective actions determined by the member and/or his/her representative to help ensure the member's health and safety.

54. Section 2.16 shall be deleted and replaced as follows:

2.16 MARKETING

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

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

2.16.1.2 Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;

2.16.1.3 Offers of gifts or material or financial gain as incentives to enroll;

2.16.1.4 Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

2.16.1.5 Direct solicitation of prospective enrollees;

2.16.1.6 Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

2.16.1.7 Assertions or statements (whether oral or written) that the enrollee must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits;

2.16.1.8 Assertions or statements (whether written or oral) that the CONTRACTOR is endorsed by CMS, the federal or state government or similar entity;

2.16.1.9 Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions; and

2.16.1.10 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

2.16.2 The prohibition on enrollee marketing shall not apply to health education and outreach activities (see Section 2.7.3) that are prior approved in writing by TENNCARE. All health education and outreach activities must be prior approved in writing by TENNCARE.

2.16.3 The CONTRACTOR shall not use the name of the CONTRACTOR's TennCare MCO in any form of general marketing (as defined in Section 1) without TENNCARE's prior written approval.

55. Section 2.17.2 shall be amended by adding a new Sub-Section 2.17.2.9 which shall read as follows:

2.17.2.9 The CONTRACTOR shall use the approved glossary of required Spanish terms in the Spanish translation of all member materials.

56. Section 2.17.4.7.36 shall be amended by deleting the reference to "Section 2.17.8.2" and replacing it with the reference "Section 2.17.9.2".

57. Section 2.18.1.9 shall be deleted and replaced as follows:

2.18.1.9 The CONTRACTOR shall ensure that calls received during normal business hours that require immediate attention by a care coordinator are immediately transferred to a care coordinator as a "warm transfer"; that calls received after normal business hours that require immediate attention are immediately addressed or transferred to a care coordinator in accordance with Section 2.18.1.6; that calls for a member's care coordinator or care coordination team during normal business hours are handled in accordance with Section 2.9.6.11.7; that calls transferred to the FEA during business hours are "warm transfers"; that calls to other CONTRACTOR staff, at a minimum, occur without the caller having to disconnect or place a second call; and that messages to care coordinators and other CONTRACTOR are returned by the next business day.

58. Section 2.18.4.10.2 shall be amended by deleting the reference to "Section 2.30.12.1" and replacing it with the reference "Section 2.30.12".

59. Section 2.18.5.3.15 shall be amended by deleting the reference to "Section 2.12.9.3.7" and replacing it with the reference "Section 2.12.9.37".

60. Section 2.18.6.2 shall be amended by adding a period "." to the end of the text.

61. Section 2.18.6.3.15 shall be amended by deleting the comma "," and adding the text "/CPS" after the acronym "APS".

62. Section 2.18.6.11 shall be amended by deleting the reference to "Section 2.18.6.5" and replacing it with the reference "Section 2.18.6.11".

63. Section 2.18.7.4 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. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

64. Section 2.18.7 shall be amended by adding a new Sub-Section 2.18.7.5 which shall read as follows:

2.18.7.5 The CONTRACTOR shall conduct an annual satisfaction survey of CHOICES long-term care providers that shall include any questions specified by TENNCARE. Instructions specific to the CHOICES survey will be provided by TENNCARE within the first three (3) months of CHOICES implementation.

65. Section 2.18.9 shall be deleted and replaced as follows:

2.18.9 **FEA Education and Training**

The CONTRACTOR shall provide education and training to the FEA and its staff and subcontracted support brokers (as applicable) regarding key requirement in this Agreement and the contract between the CONTRACTOR and the FEA (see Section 2.9.7.3 of this Agreement).

66. Section 2.21.8.2 shall be amended by deleting the word "subcontract" and replacing it with the word "contract" and by deleting the reference "(see Section 2.26.6)".

67. Section 2.21.11.1 shall be amended by deleting the reference to "Section 2.30.15.4.3" and replacing it with the reference "Section 2.30.15.4.5".

68. Section 2.22.4.4.2 shall be amended by adding the word "services" after the words "nursing facility".

69. Section 2.22.8.4 shall be amended by deleting the reference to "Section 2.22.8" and replacing it with the reference "Section 2.22.7".

70. Section 2.23.2 shall be amended by adding a new 2.23.2.1 and renumbering the existing Sections accordingly including all references thereto.

2.23.2.1 <u>HIPAA and HITECH</u>

The parties warrant that they are familiar with the Federal regulations under HIPAA and HITECH and agree to comply with the provisions as amended and to the extent the following apply: "Individually Identifiable Health Information," "Protected Health Information," "Unsecured PHI," "Safeguarding Enrollee Information," and "Privacy Breach".

71. The last sentence of Section 2.24.4.3 shall be amended by deleting and replacing the word "subcontract" with the word "contract".

72. Section 2.25.9 shall be amended by deleting Sub-Sections 2.25.9.2 through 2.25.9.4.

73. Section 2.25.10.1 through 2.25.10.14 shall be deleted and replaced as follows:

2.25.10.1 Quarterly and annual monitoring to ensure that CHOICES members receive appropriate disease management interventions and the adequacy and appropriateness of these interventions based on stratification and setting. (See Section 2.30.5).

2.25.10.2 Quality of care activities will be monitored through information obtained in a quarterly *CHOICES Care Coordination Report* (see Section 2.30.6.7) and through activities performed by the Quality Oversight Division of TennCare. These activities may include monitoring and technical assistance through site visits to the CONTRACTOR, chart audits, phone calls, etc. TENNCARE may validate the *CHOICES Care Coordination* report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.3 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Agreement regarding processes for identifying, assessing, and transitioning CHOICES who may have the ability and/or desire to transition from a nursing facility to the community. TENNCARE will review the *CHOICES Nursing Facility to Community Transition* reports submitted by the CONTRACTOR (see Section 2.30.6.4) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.4 Monthly monitoring regarding missed and late visits. TENNCARE will review the *CHOICES HCBS Late and Missed Visits* reports submitted by the CONTRACTOR (see Section 2.30.6.5) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.5 Periodic case reviews will be conducted at the discretion of TENNCARE in order to assess the CONTRACTOR's needs assessment and care planning processes..

2.25.10.6 Quarterly monitoring of the CONTRACTOR's provider network file (see Section2.30.7) to ensure that CHOICES provider network requirements are met (see Section 2.11.6).

2.25.10.7 Annual monitoring of the CONTRACTOR's long-term care provider network development plan to ensure that the CONTRACTOR is making sufficient progress towards meeting its network development and expansion goals (see Section 2.11.6.6). TENNCARE will review the plan provided by the CONTRACTOR (see Section 2.30.7.6) and will evaluate the adequacy of the CONTRACTOR's long-term care network and the CONTRACTOR's efforts to improve the network where deficiencies exist.

2.25.10.8 Quarterly monitoring of critical incidents. TENNCARE will review the *CHOICES HCBS Critical Incidents* reports submitted by the CONTRACTOR (see Section 2.30.11.7) to

identify potential performance improvement activities. TENNCARE may conduct a more in-depth review and/or request additional information.

2.25.10.9 Quarterly monitoring of the CONTRACTOR's member complaints process to determine compliance with timeframes prescribed in Section 2.19.2 of this Agreement and appropriateness of resolutions. TENNCARE will review the Member Complaints reports submitted by the CONTRACTOR (see Section 2.30.13), to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.10 Review of all reports from the CONTRACTOR (see Section 2.30) and any related follow-up activities.

74. Section 2.26.5 shall be deleted and replaced as follows:

2.26.5 **Subcontracts for Assessments and Plans of Care**

If the CONTRACTOR subcontracts with an entity specifically to conduct care coordination functions, including level of care or needs assessments or reassessments and/or developing or authorizing plans of care (see Section 2.9.6), such subcontractor shall not provide any direct long-term care services. This does not preclude nursing facilities or hospitals contracted with the CONTRACTOR to deliver services from completing and submitting pre-admission evaluations.

75. Section 2.26.6 shall be deleted and replaced as follows:

2.26.6 **Contract with Fiscal Employer Agent (FEA)**

As required in Section 2.9.7.3, the CONTRACTOR shall contract with TENNCARE's designated FEA to provide assistance to members choosing consumer direction of HCBS. The CONTRACTOR shall not be liable for any failure, error, or omission by the FEA related to the FEA's verification of worker qualifications.

76. Section 2.26.12.1 shall be deleted and replaced 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, 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.

77. The first sentence of Section 2.27.2.13.3 shall be amended by adding the word "of" after the word "days".

78. Section 2.28 shall be deleted and replaced as follows:

2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

2.28.1 The CONTRACTOR shall comply with Section 4.32 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.

2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the 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 provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding the CONTRACTOR's non-discrimination policies and procedures and all applicable non-discrimination compliance requirements of the TennCare program. The CONTRACTOR shall be able to show documented proof of such instruction.

2.28.3 The CONTRACTOR shall develop written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section 2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.

2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.

2.28.5 The CONTRACTOR shall ask all staff to provide their race or ethnic origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.

2.28.6 The CONTRACTOR shall ask all providers for their race or ethnic origin. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

2.28.7 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees, enrollees, providers and subcontractors related to the provision of and 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, if resolved; and name of CONTRACTOR staff person responsible for adjudication of the complaint.

2.28.8 The CONTRACTOR shall develop and have available a standardized complaint form to provide to a complainant upon request. This complaint form shall be in a format specified by TENNCARE.

2.28.9 The CONTRACTOR shall report on non-discrimination activities as described in Section 2.30.21.

79. The second sentence of Section 2.29.1.3.5 shall be amended by adding a period "." after the word "TENNCARE".

80. Section 2.29.1.3.9 shall be deleted and replaced as follows:

2.29.1.3.9 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), 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) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

81. Section 2.29.1.3.12 shall be deleted and replaced as follows:

2.29.1.3.12 A full-time staff person dedicated to the TennCare CHOICES program responsible for educating and assisting long-term care providers and the FEA regarding appropriate claims submission processes and requirements, coding updates, electronic claims transactions and electronic funds transfer; for the development and maintenance of CONTRACTOR resources such as CHOICES provider manuals, website, fee schedules, etc.; for technical assistance regarding long-term care claims submission and resolution processes; and for prompt resolution of long-term care claims issues or inquiries as specified in Section 2.22.5. This person shall develop strategies to assess the effectiveness of the CONTRACTOR's claims education and technical assistance activities, gather feedback regarding the extent to which CHOICES long-term care providers are informed about appropriate claims submission processes and practices, and

identify trends and guide the development of strategies to improve the efficiency of long-term care claims submission and resolution processes, as well as provider satisfaction;

82. Section 2.29.1.3.15 and Section 2.29.1.4 shall both be amended by deleting the words "quality management" and replacing them with "QM/QI".

83. Section 2.30.4.9 shall be deleted in its entirety and the remaining Sub-Sections shall be renumbered accordingly, including any references thereto.

84. Section 2.30.4.11 shall be deleted in its entirety.

85. Section 2.30.5 shall be deleted and replaced as follows:

2.30.5 **Disease Management Reports**

2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. 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. 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.

2.30.5.3 The CONTRACTOR shall submit annually an updated *Disease Management Program Description* to include at a minimum the disease management components listed in Sections 2.8.1.4 through 2.8.1.6 of this Agreement.

86. Section 2.30.6 shall be deleted and replaced as follows:

2.30.6 **Service Coordination Reports**

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 The CONTRACTOR shall submit annually an updated *MCO Case Management Program Description* to TENNCARE describing the CONTRACTOR's MCO case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for MCO case management, the process the CONTRACTOR uses to inform members and providers of the availability of MCO case management, a description of the MCO case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its MCO case management program. CHOICES information shall also be included in this report.

2.30.6.1.2 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.5 of this Agreement by July 1 of each year.

2.30.6.1.3 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report.* Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management.

2.30.6.2 For the first six (6) months after implementation of CHOICES in the Grand Region covered by this Agreement, or as long as determined necessary by TENNCARE, the CONTRACTOR shall submit a monthly *Status of Transitioning CHOICES Members Report* that provides information regarding transitioning CHOICES members (see Section 2.9.3). The report shall include information on the CONTRACTOR's current and cumulative performance on various measures.

The performance measures shall include but not be limited to the following:

(1) Of CHOICES Group 1 members who were enrolled in CHOICES as of the CHOICES implementation date, the number and percent for whom the CONTRACTOR has/has not conducted a face-to-face visit (see Section 2.9.3.7)

(2) Of CHOICES Group 2 members who were enrolled in CHOICES as of the CHOICES implementation date, the number and percent for whom the CONTRACTOR has/has not conducted face-to-face visit and a comprehensive needs assessment and developed and authorized a new plan of care

2.30.6.3 The CONTRACTOR shall submit a semi-annual *CHOICES Nursing Facility Diversion Activities Report*. The report shall provide a description of the CONTRACTOR's nursing facility diversion activities by each of the groups specified in Section 2.9.6.7, including a detailed description of the CONTRACTOR's success in identifying members for diversion, in diverting members, and in maintaining members in the community, as well as lessons learned, including a description of factors affecting the CONTRACTOR's ability to divert members, identified issues, strategies to address identified issues, and opportunities for systemic improvements in the CONTRACTOR's nursing facility diversion process(es).

2.30.6.4 The CONTRACTOR shall submit a quarterly *CHOICES Nursing Facility to Community Transition Report*. The report shall include information, by month, on specified measures, which shall include but not be limited to the following:

(1) Number of CHOICES members transitioned from a nursing facility

(2) Of members who transitioned from a nursing facility, the number and percent of members who transitioned to:
(a) A community-based residential alternative facility
(b) A residential setting where the member will be living independently
(c) A residential setting where the member will be living with a relative or other caregiver

(3) Of members who transitioned from a nursing facility, the number and percent of members who:
(a) Are still in the community
(b) Returned to a nursing facility within ninety (90) days after transition
(c) Returned to a nursing facility more than ninety (90) days after transition

(4) Number of CHOICES members identified as potential candidates for transition from a nursing facility

(5) Of members identified as potential candidates for transition, the number and percent of members who were identified:
(a) By referral (by type of referral, including but not limited to referral by treating physician, nursing facility, community-based organization, family, self, and other)
(b) Via the MDS
(c) Via care coordination
(d) By other source

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter after CHOICES implementation.

2.30.6.5 The CONTRACTOR shall submit a monthly *CHOICES HCBS Late and Missed Visits Report* for CHOICES members regarding the following HCBS services: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include information on specified measures, which shall include but not be limited to the following:

(1) Total number of members enrolled in Group 2, Group 3, and in Groups 2 and 3 combined

(2) Total number of CHOICES members with scheduled visits for each service type (personal care, attendant care, homemaker, and home-delivered meals), by provider type (agency provider or consumer-directed worker)

(3) Total number of scheduled visits for each service type, by provider type

(4) Of the total number of scheduled visits for each service type, by provider type; the percent that were:
(a) On-time
(b) Late
(c) Missed

(5) Of the total number of late visits for each service type, by provider type; the percent that were:
(a) Member-initiated
(b) Provider-initiated
(c) Due to weather/natural disaster

(6) Of the total number of late visits for each service type, by provider type; the number that were:
(a) Member-initiated, by reason code
(b) Provider-initiated, by reason code
(c) Due to weather/natural disaster

(7) Of the total number of missed visits for each service type, by provider type; the percent that were:
(a) Member-initiated
(b) Provider-initiated
(c) Due to weather/natural disaster

(8) Of the total number of missed visits for each service type, by provider type; the number that were:
(a) Member-initiated, by reason code
(b) Provider-initiated, by reason code
(c) Due to weather/natural disaster

(9) Of the total number of missed visits for each service type, by provider type; the number and percent that were:
(a) Made-up by paid support – provider staff
(b) Made-up by paid support – worker
(c) Made-up by unpaid support
(d) Not made-up

2.30.6.6 The CONTRACTOR shall submit a quarterly *CHOICES Consumer Direction of HCBS Report*. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:

(1) Total number of members enrolled in Group 2, Group 3, and in Groups 2 and 3 combined

(2) The number and percent of members in Groups 2 and 3 (combined) enrolled in consumer direction of HCBS

(3) Number of members referred to the FEA (for enrollment in consumer direction)

(4) Maximum and average time from FEA referral to receipt of consumer-directed services

(5) Number and percent of members enrolled in consumer direction who began initial enrollment in consumer direction (for each month in the reporting period)

(6) Number and percent of members enrolled in consumer direction who withdrew from consumer direction (for each month in the reporting period)

(7) Number and percent of members enrolled in consumer direction who have a representative to assist the member in consumer direction

(8) The number and percent of member receiving consumer-directed services by type of consumer-directed service (attendant care, companion care, homemaker, in-home respite, or personal care)

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter.

2.30.6.7 The CONTRACTOR shall submit a quarterly *CHOICES Care Coordination Report*, in a format specified by TENNCARE that includes, but is not limited to, information on care coordination staffing, enrollment and care coordination contacts, ongoing assessment, care planning and service initiation, and self-directed healthcare tasks. The report shall also include a narrative of quarterly activities.

2.30.6.8 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.10.3.2).

2.30.6.9 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.

2.30.6.10 The CONTRACTOR shall submit a *Pharmacy Services Report, On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

87. Section 2.30.7.3 shall be deleted and replaced as follows:

2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. (See Section 2.11.2.)

88. Section 2.30.7.8 shall be deleted and replaced as follows:

2.30.7.8 The CONTRACTOR shall submit an annual *CHOICES Qualified Workforce Strategies Report* that describes the CONTRACTOR's strategies to assist in the development of an adequate qualified workforce for covered long-term care services, increase the available qualified direct care staff, and improve the retention of qualified direct care staff (see Section 2.11.6.7). At a minimum, the report shall include a brief description of each of the CONTRACTOR's strategies; activities associated with each of the CONTRACTOR's strategies, including associated partnerships; timeframes for implementing each strategy and associated activities; the status of each strategy and associated activities; and a brief summary of the current and anticipated impact of each strategy and associated activities.

89. Section 2.30.9.4 shall be deleted and replaced as follows:

2.30.9.4 The CONTRACTOR shall provide a monthly *Reconciliation Report* for the total paid amounts between the funds released for payment to providers and the FEA (for consumer-directed workers), the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The *Reconciliation Report* shall be submitted the month after the claims data extract is submitted.

90. 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 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.

91. Section 2.30.11.5 shall be deleted and replaced as follows:

2.30.11.5 The CONTRACTOR shall submit an annual *Report of Audited CAHPS Results* and *Audited HEDIS Results* by June 15 of each year (see Sections 2.15.6).

92. Section 2.30.11.6 shall be deleted in its entirety and the remaining Sub-Sections in Section 2.30.11 shall be renumbered accordingly, including any references thereto.

93. The renumbered Section 2.30.11.6 shall be deleted and replaced as follows:

2.30.11.6 The CONTRACTOR shall submit a quarterly *CHOICES HCBS Critical Incidents Report* (see Section 2.15.8) that provides information, by month regarding specified measures, which shall include but not be limited to the following:

(1) The number of members in Group 2, Group 3, and Groups 2 and 3 combined

(2) The number of critical incidents, overall and by:

(a) Type of incident
(b) Setting
(c) Type of provider (provider agency or consumer directed worker)

(3) The percent of incidents by type of incident

(4) The percent of members in Groups 2 and 3 with an incident

94. Section 2.30.12.1.1 shall be deleted and replaced in its entirety.

2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services, Provider Services, and Utilization Management Phone Line Report.* The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

95. 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 survey 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.

96. Section 2.30.13 shall be deleted and replaced as follows

2.30.13 Member Complaints

Upon receipt of a reporting template from TENNCARE and in accordance with specified timeframes for implementing the new report, the CONTRACTOR shall begin submitting a quarterly *Member Complaints Report* (see Section 2.19.2) that includes information, by month, regarding specified measures, which shall include but not be limited to the following:

(1) The number of complaints received in the month, overall, by type, and by CHOICES Group (if the member is a CHOICES member)

(2) The number and percent of complaints for which the CONTRACTOR met/did not meet the specified timeframe for resolution (see Section 2.19.2.5).

The report shall also include identification of any trends regarding complaints (e.g., the type or number of complaints) and any action steps to address these trends, including quality improvement activities.

97. Section 2.30.15.2 shall be deleted in its entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

98. Renumbered Section 2.30.15.2.1 shall be amended by deleting the reference to "September" and replacing it with the reference "August".

99. Renumbered Section 2.30.15.2.3 shall be amended by deleting the reference to "Section 2.30.48" and replacing it with the reference to "Section 2.21.10".

100. Renumbered Section 2.30.15.3.3 shall be amended by deleting the reference to "TCA 56-32-208" and replacing it with the reference "TCA 56-32-108".

101. Renumbered Section 2.30.15.3.4 shall be amended by deleting the reference to "September 1" and replacing it with the reference "August 15".

102. Section 2.30.16.4 through 2.30.16.6 shall be deleted and the remaining Section 2.30.16.7 shall be renumbered as 2.30.16.4 including any references thereto.

103. The renumbered Section 2.30.16.4 shall be deleted and replaced as follows:

2.30.16.4 The CONTRACTOR shall submit a quarterly *CHOICES Cost Effective Alternatives Report* that provides information on cost effective alternative services provided to CHOICES members (see Section 2.6.5.2). The report shall provide information regarding specified measures, including but not limited to the following:

(1) The number of members in Group 2, Group 3, and Groups 2 and 3 combined

(2) The number and percent of members authorized to receive cost effective alternative (CEA) HCBS in excess of a benefit limit, overall and by service

(3) For members transitioning from a nursing facility to the community, the number of members authorized to receive a transition allowance as a CEA, the total amount of transition allowances authorized, the average transition allowance authorized

(4) A summary of items purchased with a transition allowance, including the most frequent categories of expenditure

(5) The number and percent of members authorized to receive other non-covered HCBS as a CEA

(6) A summary of other non-covered HCBS authorized as a CEA, identifying the most frequently authorized services

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter.

104. Section 2.30.18.2 shall be deleted and replaced as follows:

2.30.18.2 The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CHOICES Advisory Group* regarding the activities of the CHOICES advisory group established pursuant to Section 2.24.3. This report shall include the membership of the advisory group (name, address, and organization represented), a description of any orientation and/or ongoing training activities for advisory group members, and information on advisory group meetings, including

the date, time, location, meeting attendees, and minutes from each meeting. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

105. Section 2.30.21 shall be deleted and replaced as follows:

2.30.21 **Non-Discrimination Compliance Reports**

2.30.21.1 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in the provision of services to members. The policy shall demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats. This shall include a report that lists all interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, languages spoken, and hours services are available.

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

2.30.21.3 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan* and *Assurance of Non-Discrimination* to TENNCARE. The signature date of the CONTRACTOR's Plan shall coordinate with the signature date of the CONTRACTOR's Assurance of Non-Discrimination.

2.30.21.4 The CONTRACTOR shall submit a quarterly *Non-discrimination Compliance Report* which shall include the following:

2.30.21.4.1 A summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE:

2.30.21.4.2 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, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint; and

2.30.21.4.3 A listing of all member requests for language and communication assistance. The report shall list the member, the member's identification number, the date of the request, the date the service was provided and the name of the service provider.

106. Section 3.7.1.3 shall be amended by deleting the reference to "Section 2.6.7.2" and replacing it with the reference "Section 2.6.7".

107. Section 3.10.1.3 shall be deleted and replaced as follows:

3.10.1.3 In the first year that the incentives specified in Sections 3.10.2 are available, the TennCare regional average HEDIS score (as calculated by TENNCARE using audited MCO HEDIS results) for each of the measures specified in Sections 3.10.2 for the last full calendar year prior to the year that the CONTRACTOR began operating under this Agreement will serve as the baseline. If complete TennCare HEDIS data for these measures is not available for the region for the year prior to the year that the CONTRACTOR began operating under this Agreement, then the last year for which complete data is available will serve as the baseline.

108. Section 3.10.3 shall be deleted and replaced as follows:

3.10.3.3 **Behavioral Health HEDIS Measures**

3.10.3.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR's HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. To be eligible for incentive payment for a measure, the CONTRACTOR must demonstrate significant improvement for both rates comprising the measure. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.4 below).

3.10.3.2 Audited HEDIS Measures:

3.10.3.2.1 Antidepressant Medication Management;

3.10.3.2.2 Follow-up Care for Children Prescribed ADHD Medication; and

3.10.3.2.3 Follow-Up After Hospitalization for Mental Illness.

109. Section 3.10.4 shall be deleted in its entirety and the remaining Sub-Section of Section 3.10 shall be renumbered accordingly, including any references thereto.

110. Section 3.14.1.1 shall be deleted and replaced as follows:

3.14.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed Three Billion, Three Hundred Forty-Five Million, Nine Hundred Forty-Nine Thousand, Seven Hundred Six Dollars ($3,345,949,706.00).

111. Section 4.2.1 shall be amended by deleting the reference to "June 30, 2010" and replacing it with the reference to "June 30, 2011".

112. Section 4.3 shall be amended by adding new Section 4.3.11, 4.3.12, and 4.3.13 as described below and renumbering existing sub-Sections accordingly, including any references thereto.

4.3.11 The Church Amendments (42 U.S.C. 300a-7).

4.3.12 Section 245 of the Public Health Service (PHS) Act (42 U.S.C. 238n).

4.3.13 Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209).

113. The renumbered Section 4.3.19 and Section 4.3.20 shall be amended by deleting and replacing the TCA citations as follows:

4.3.19 Requests for approval of material modification as provided at TCA 56-32-101 *et seq.*

4.3.20 Investigatory Powers of TDCI pursuant to TCA 56-32-132.

114. Section 4.20.1.1 shall be amended by deleting the reference to "Section 2.25.9" and replacing it with the reference "Section 2.25.11".

115. Section 4.20.1.2.8 shall be amended by deleting and replacing the word "recipients" with the word "members".

116. Sections 4.20.2.2.1 through 4.20.2.2.4 shall be deleted and replaced as follows:

4.20.2.2.1 Liquidated damages for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below. Damages are grouped into three categories: **Level A, Level B,** and **Level C** program issues.

4.20.2.2.2 Failure to perform specific responsibilities or requirements categorized as **Level A** are those which pose a significant threat to patient care or to the continued viability of the TennCare program

4.20.2.2.3 Failure to perform specific responsibilities or requirements categorized as **Level B** are those which pose threats to the integrity of the TennCare program, but which do not necessarily imperil patient care.

4.20.2.2.4 Failure to perform specific responsibilities or requirements categorized as **Level C** are those which represent threats to the smooth and efficient operation of the TennCare program but which do not imperil patient care or the integrity of the TennCare program.

117. Section 4.20.2.2.7 shall be deleted and replaced as follows, updating all references accordingly, including any references thereto.

4.20.2.2.7 *Liquidated Damages Chart*

LEVEL	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in Section 2.22 of this Agreement		$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2.22 of this Agreement
A.2	Failure to comply with licensure and background check requirements in Section 2.29.2 and Attachment XI of this Agreement		$5,000 per calendar day that staff/provider/ /driver/agent/subcontractor is not licensed or qualified as required by applicable state or local law plus the amount paid to the staff/provider/driver/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody		The actual amount paid by DCS and/or TENNCARE for necessary services or $1,000, whichever is greater
A.4	Failure to comply with obligations and time frames in the delivery of TENNderCare screens and related services		The actual amount paid by DCS and/or TENNCARE for necessary services or $1,000, whichever is greater
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer		The actual amount paid by DCS and/or TENNCARE for necessary services or $1,000, whichever is greater

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES		DAMAGE
A.6(a)	Failure to provide a service or make payments for a service within five (5) calendar days of a directive from TENNCARE (pursuant to an appeal) to do so, or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$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.6(b)	Failure to provide proof of compliance to TENNCARE within five (5) calendar days of a directive from TENNCARE or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$500 per day beginning on the next calendar day after default by the CONTRACTOR
A.7	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2.7.8 of this Agreement		$500 per occurrence or the actual amount of the federal penalty created by the CONTRACTOR's failure to comply, whichever is greater
A.8	Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 2.7.5 of this Agreement		$500 per day, per occurrence, for each calendar day that care is not provided in accordance with the terms of this Agreement

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
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 beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE
A.10.(a) **A.10.(b)**	Failure to comply with the notice requirements of this Agreement, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member	$500 per occurrence in addition to $500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE $1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1,000 for the second day, $1,500 for the third day, etc.) for each day the notice is late and/or remains defective
A.11	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days	$500 per calendar day
A.12	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective	$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
A.13	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective	First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TENNCARE) Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" ($500 per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; $1,000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)
A.14	Failure to (1) provide an approved service timely, i.e., in accordance with timelines specified in this Agreement, or when not specified therein, with reasonable promptness; or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The cost of services not provided plus $500 per day, per occurrence, for each day (1) that approved care is not provided timely; or (2) notice of delay is not provided and/or the CONTRACTOR fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
A.15	Failure to acknowledge or act timely upon a request for prior authorization in accordance with TennCare rules and regulations	The cost of services not provided plus $500 per day, per occurrence, for each day that it is determined the CONTRACTOR failed to acknowledge or act timely upon a request for prior authorization in accordance with TennCare rules and regulations

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
A.16	Failure to comply with the timeframes for developing and approving a plan of care for transitioning CHOICES members in Group 2, authorizing and initiating nursing facility services for transitioning CHOICES members in Group 1, or initiating long-term care services for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6)	$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS) $10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS) $15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS) $20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS) $25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS)
A.17	Failure to meet the performance standards established by TENNCARE regarding missed visits for personal care, attendant care, homemaker, or home-delivered meals for CHOICES members (referred to herein as "specified HCBS")	$5,000 per month that 11-15% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $10,000 per month that 16-20% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $15,000 per month that 21-25% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $20,000 per month that 26-30% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $25,000 per month that 31% or more of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS
B.1	Failure to provide referral provider listings to PCPs as required by Section 2.14.3.5 of this Agreement	$500 per calendar day
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE	$500 per calendar day for each day the corrective action is not completed or complied with as required
B.3	Failure to submit Audited HEDIS and CAHPS results annually by June 15 as described in Sections 2.15.5 and 2.15.6	$250 per day for every calendar day reports are late
B.4	Failure to submit NCQA Accreditation Report as described in Section 2.15.5	$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES		DAMAGE
B.5	Failure to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements described in Section 4.19, 4.23, or 4.24, or 2.12.9.48		110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals
B.6	Failure to disclose Lobbying Activities and/or quarterly conflict of interest disclosure as required by Section 4.24, 4.19, or 2.12.9.48		$1,000 per day that disclosure is late
B.7	Failure to obtain approval of member materials as required by Section 2.17 of this Agreement		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided member material that has not been approved by TENNCARE
B.8	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, Quarterly Member Newsletters, and CHOICES member education materials as required in Section 2.17		$5,000 for each occurrence
B.9	If the CONTRACTOR knew or should have known that a member has not received long-term care services for thirty (30) days or more, failure to report on that member in accordance with Section 2.30.10.5 (see also Section 2.6.1.5.7)		For each member, an amount equal to the CHOICES capitation rate prorated for the period of time in which the member did not receive long-term care services
B.10	Failure to achieve and/or maintain financial requirements in accordance with TCA		$500 per calendar day for each day that financial requirements have not been met
B.11	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.30.15.4		$500 per calendar day
B.12	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.30.15.4		$500 per calendar day
B.13	Failure to submit audited financial statements as described in Section 2.30.15.4		$500 per calendar day

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
B.14	Failure to comply with fraud and abuse provisions as described in Section 2.20 of this Agreement	$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions
B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.9.60 of this Agreement	$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B
B.16	Failure to maintain a complaint and appeal system as required in Section 2.19 of this Agreement	$500 per calendar day
B.17	Failure to comply with the timeframe for resolving complaints (see Section 2.19.2)	$1,000 per month that the CONTRACTOR's performance is 85-89% $2,000 per month that the CONTRACTOR's performance is 80-84% $3,000 per month that the CONTRACTOR's performance is 75-79% $4,000 per month that the CONTRACTOR's performance is 70-74% $5,000 per month that the CONTRACTOR's performance is 69% or less
B.18	Failure to maintain required insurance as required in Section 2.21.8 of this Agreement	$500 per calendar day
B.19	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.9.3.2 of this Agreement	$1,000 per occurrence per case
B.20	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement	$500 per occurrence
B.21	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.7.2.9 of this Agreement	$500 per month per Enrollee

Amendment Number 5 (cont.)

LEVEL	PROGRAM ISSUES		DAMAGE
B.22	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.7.2.9 of this Agreement		$500 per occurrence per case
B.23	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17		$1,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% $2,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% $3,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% $4,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% $5,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less
B.24	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required in Section 2.11.8 of this Agreement		$5,000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable And/Or $1,000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed as described in Section 2.11.8 of this Agreement
B.25	Failure to maintain provider agreements in accordance with Section 2.12 and Attachment XI of this Agreement		$5,000 per provider agreement found to be non-compliant with the requirements outlined in this Agreement
B.26	Failure to comply with the requirements regarding an agreement to audit accounts (Section 2.21.11)		$1,500 for each day after December 1 of each year that the fully executed agreement for audit accounts is not submitted or for each day after December 1 of each year that the fully executed agreement does not include the required language
C.1	Failure to comply in any way with staffing requirements as described in Section 2.29.1 of this Agreement		$250 per calendar day for each day that staffing requirements are not met

LEVEL	PROGRAM ISSUES	DAMAGE
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's MCO	$250 per day
C.3	Failure to comply in any way with encounter data submission requirements as described in Section 2.23 of this Agreement (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE)	$25,000 per occurrence
C.4	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE
C.5	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 2.4.9.5	$1,000 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of $5,000 per occurrence
C.6	Failure to comply with the requirements regarding documentation for CHOICES members (see Section 2.9.6)	$500 per plan of care for members in Group 2 or 3 that does not include all of the required elements $500 per member file that does not include all of the required elements $500 per face-to-face visit where the care coordinator fails to document the specified observations
C.7	Failure to submit a Provider Enrollment File that meets TENNCARE's specifications (see Section 2.30.7.1)	$250 per day after the due date that the Provider Enrollment File fails to meet TENNCARE's specifications

118. Section 4.27 shall be amended by deleting the word "which" and replacing it with the word "that".

119. Section 4.32.1 shall be amended by adding the word ", beliefs" after the word "religion".

120. Section 4.34 shall be deleted and replaced as follows:

4.34 PROHIBITION OF ILLEGAL IMMIGRANTS

4.34.1 The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Agreement, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Agreement.

4.34.2 The CONTRACTOR hereby attests, certifies, warrants, and assures that the CONTRACTOR shall not knowingly utilize the services of an illegal immigrant in the performance of this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Agreement. The CONTRACTOR shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment X, hereto, semi-annually during the period of this Agreement. Such attestations shall be maintained by the CONTRACTOR and made available to state officials upon request.

4.34.3 Prior to the use of any subcontractor in the performance of this Agreement, and semi-annually thereafter, during the period of this Agreement, the CONTRACTOR shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Agreement. Attestations obtained from such subcontractors shall be maintained by the CONTRACTOR and made available to state officials upon request.

4.34.4 The CONTRACTOR shall maintain records for all personnel used in the performance of this Agreement. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

4.34.5 The CONTRACTOR understands and agrees that failure to comply with this Section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Agreement.

4.34.6 For purposes of this Agreement, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Agreement.

121. Attachment V shall be deleted in its entirety and replaced with the following:

ATTACHMENT V

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the

purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Travel distance does not exceed 75 miles for at least 75% of **ADULT** members and does not exceed 150 miles for at least 90% of **ADULT** members ---------- Travel distance does not exceed 60 miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency

24 Hour Residential Treatment Services (Substance Abuse)	Travel distance does not exceed 75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support	Not subject to geographic access standards	Within 10 business days
Supported Housing	Travel distance does not exceed 60 miles for at least 75% of **ADULT** members and does not exceed 90 miles for at least 90% of **ADULT** members	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

When the above standards are not met, an acceptable Corrective Action Plan will be requested which details the CONTRACTOR's intended course of action to resolve any deficiency (ies) identified. The Bureau of TennCare will evaluate Corrective Action Plans and, at its sole discretion, determine network adequacy considering any alternate measures and documentation of unique market conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2

Amendment Number 5 (cont.)

Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult – 41

122. Attachment VI, Performance Standards shall be amended by deleting and replacing the existing Items 3 through 6 with new Items 3 through 10 and renumbering the remaining Items accordingly, including any references thereto.

Amendment Number 5 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness -Provider Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
5	Telephone Response Time/Call Answer Timeliness - Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
6	Telephone Response Time/Call Answer Timeliness – Nurse Triage/Nurse Advice Line	Nurse Triage/Nurse Advice Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
7	Telephone Call Abandonment Rate (unanswered calls) – Member Services	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the	Quarterly	$25,000 for each full percentage point above 5% per month

Amendment Number 5 (cont.)

	Line			number of calls received by the phone line (during open hours of operation) during the measurement period		
8	Telephone Call Abandonment Rate (unanswered calls) – Provider Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month
9	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month
10	Telephone Call Abandonment Rate (unanswered calls) – Nurse Triage/Nurse Advice Line	Nurse Triage/Nurse Advice Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month

123. The Deliverable Items in Attachment VIII shall be deleted and replaced as follows:

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the TennCare Bureau unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Policies and procedures for patient liability that ensure compliance with Section 2.6.7.2

6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3

7. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.4

8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6

9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7

10. Disease management program policies and procedures that ensure compliance with Section 2.8

11. Service coordination policies and procedures that ensure compliance with Section 2.9.1

12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3

14. Transition of care polices and procedures that ensure compliance with Section 2.9.4

15. MCO case management policies and procedures that ensure compliance with Section 2.9.5

16. Care coordination policies and procedures that ensure compliance with Section 2.9.6

17. Policies and procedures for consumer direction of HCBS that ensure compliance with Section 2.9.7

18. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section 2.9.8

19. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.8.2 to ensure compliance with Section 2.9.8

20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.9

21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.10

22. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.11

23. Identification of members serving on the claims coordination committee in accordance with Section 2.9.11.5.3

24. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.12

25. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.14

26. Polices and procedures regarding non-covered services that ensure compliance with Section 2.10

27. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

28. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

29. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

30. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8

31. Policies and procedures that ensure compliance with notice requirements in Section 2.11.9

32. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.9.2

33. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

34. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.9.49)

35. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.8)

36. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.8)

37. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.9.1

38. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9

39. Information on PCP profiling as requested by TENNCARE (see Section 2.14.9)

40. QM/QI policies and procedures to ensure compliance with Section 2.15

41. Copy of signed contract with NCQA approved vendor to perform CAHPS as required by Section 2.15.5

42. Copy of signed contract with NCQA approved vendor to perform HEDIS audit as required by Section 2.15.5

43. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.5.1)

44. HEDIS BAT as required by Section 2.15.6

45. Copy of signed NCQA survey contract as required by Section 2.15.5.1

46. Notice of date for ISS submission and NCQA on-site review as required by Section 2.15.5.1

47. Notice of final payment to NCQA as required by Section 2.15.5.1

48. Notice of submission of ISS to NCQA as required by Section 2.15.5.1

49. Copy of completed NCQA survey and final report as required by Section 2.15.5.1

50. Notice of any revision to NCQA accreditation status

51. Policies and procedures regarding critical incident management and reporting to ensure compliance with Section 2.15.8

52. If applicable, information on the use of the name of the CONTRACTOR's TennCare MCO pursuant to Section 2.16.3

53. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletters, identification card, and provider directory along with any required supporting materials

54. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

55. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

56. Provider service and phone line policies and procedures that ensure compliance with Section 2.18.4

57. Description of 24/7 ED Assistance Line (see Section 2.18.4.7)

58. Provider handbook that is in compliance with requirements in Section 2.18.5

59. Provider education and training plan and materials that ensure compliance with Section 2.18.6

60. Provider relations policies and procedures in compliance with Section 2.18.7

61. Protocols regarding one-on-one assistance to long-term care providers that ensure compliance with Section 2.18.7.2

62. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.3)

63. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

64. FEA education and training plan and materials that ensure compliance with Section 2.18.9

65. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.10

66. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

67. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

68. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

69. Fraud and abuse compliance plan (see Section 2.20.3)

70. TPL policies and procedures that ensure compliance with Section 2.21.4

71. Accounting policies and procedures that ensure compliance with Section 2.21.7

72. Proof of insurance coverage (see Section 2.21.8)

73. Executed agreement for audit accounts that contains the required language (see Section 2.21.11)

74. Claims management policies and procedures that ensure compliance with Section 2.22

75. Internal claims dispute procedure (see Section 2.22.5)

76. EOB policies and procedures to ensure compliance with Section 2.22.8

77. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

78. Proposed approach for remote access in accordance with Section 2.23.6.10

79. Information security plan as required by Section 2.23.6.11

Amendment Number 5 (cont.)

80. Notification of Systems problems in accordance with Section 2.23.7

81. Systems Help Desk services in accordance with Section 2.23.8

82. Notification of changes to Systems in accordance with Section 2.23.9

83. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

84. Notification of changes to membership of CHOICES Advisory Group and current membership lists in accordance with Section 2.24.3

85. An abuse and neglect plan in accordance with Section 2.24.4

86. Medical record keeping policies and procedures that ensure compliance with Section 2.24.6

87. Subcontracts (see Section 2.26)

88. HIPAA policies and procedures that ensure compliance with Section 2.27

89. Accounting of disclosures in accordance with Section 2.27.2.10

90. Notification of use or disclosure in accordance with Section 2.27.2.13.3.3

91. Notification of any unauthorized acquisition of enrollee PHI in accordance with Section 2.27.2.13.3

92. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27.2.27

93. Notification of any security incident in accordance with Section 2.27.3

94. Non-discrimination policies and procedures as required by Section 2.28

95. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

96. Changes to key staff as required by Section 2.29.1.2

97. Staffing plan as required by Section 2.29.1.8

98. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.9

99. Background check policies and procedures that ensure compliance with Section 2.29.2.1

100. List of officers and members of Board of Directors (see Section 2.29.3)

101. Changes to officers and members of Board of Directors (see Section 2.29.3)

102. Eligibility and Enrollment Data (see Section 2.30.2.1)

103. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)

104. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)

105. Information on members (see Section 2.30.2.4)

106. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)

107. Mental Health Case Management Report (see Section 2.30.4.2)

108. Supported Employment Report (see Section 2.30.4.3)

109. Behavioral Health Crisis Response Report (see Section 2.30.4.4)

110. Member CRG/TPG Assessment Report (see Section 2.30.4.5)

111. Rejected CRG/TPG Assessment Report (see Section 2.30.4.6)

112. CRG/TPG Assessments Audit Report (see Section 2.30.4.7)

113. Methodology for conducting CRG/TPG assessment audits (see Section 2.30.4.8)

114. TENNderCare Report (see Section 2.30.4.9)

115. Disease Management Update Report (see Section 2.30.5.1)

116. Disease Management Report (see Section 2.30.5.2)

117. Disease Management Program Description (see Section 2.30.5.3)

118. MCO Case Management Program Description (see Section 2.30.6.1.1)

119. MCO Case Management Services Report (see Section 2.30.6.1.2)

120. MCO Case Management Update Report (see Section 2.30.6.1.3)

121. Status of Transitioning CHOICES Member Report (see Section 2.30.6.2)

122. CHOICES Nursing Facility Diversion Activities Report (see Section 2.30.6.3)

123. CHOICES Nursing Facility to Community Transition Report (see Section 2.30.6.4)

124. CHOICES HCBS Late and Missed Visits Report (see Section 2.30.6.5)

125. CHOICES Consumer Direction of HCBS Report (see Section 2.30.6.6)

126. CHOICES Care Coordination Report (see Section 2.30.6.7)

127. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.8)

128. Pharmacy Services Report (see Section 2.30.6.9)

129. Pharmacy Services Report, On Request (see Section 2.30.6.10)

130. Provider Enrollment File (see Section 2.30.7.1)

131. Provider Compliance with Access Requirements Report (see Section 2.30.7.2)

132. PCP Assignment Report (see Section 2.30.7.3)

133. Report of Essential Hospital Services (see Section 2.30.7.4)

134. Behavioral Health Initial Appointment Timeliness Report (see Section 2.30.7.5)

135. Long-Term Care Provider Network Development Plan (see Section 2.30.7.6)

136. Long-Term Care Provider Capacity Performance Report (see Section 2.30.7.7)

137. CHOICES Qualified Workforce Strategies Report (see Section 2.30.7.8)

138. FQHC Reports (see Section 2.30.7.9)

139. Institutions for Mental Diseases (IMD) Out-of-State Report (see Section 2.30.7.10)

140. Single Case Agreements Report (see Section 2.30.8)

141. Related Provider Payment Report (see Section 2.30.9.1)

142. Check Run Summaries Report (see Section 2.30.9.2)

143. Claims Data Extract Report (see Section 2.30.9.3)

144. Reconciliation Payment Report (see Section 2.30.9.4)

145. UM program description, work plan, and evaluation (see Section 2.30.10.1)

146. Cost and Utilization Reports (see Section 2.30.10.2)

147. Cost and Utilization Summaries (see Section 2.30.10.3)

148. Identification of high-cost claimants (see Section 2.30.10.4)

149. CHOICES Utilization Report (see Section 2.30.10.5)

150. Prior Authorization Reports (see Section 2.30.10.6)

151. Referral Provider Listing and supporting materials (see Section 2.30.10.7)

152. ED Threshold Report (see Section 2.30.10.8)

153. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.11.1)

154. Report on Performance Improvement Projects (see Section 2.30.11.2)

Amendment Number 5 (cont.)

155. NCQA Accreditation Report (see Section 2.30.11.3)

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

157. Reports of Audited CAHPS Results and Audited HEDIS Results (see Section 2.30.11.5)

158. CHOICES HCBS Critical Incidents Report (see Section 2.30.11.6)

159. Member Services, Provider Services, and Utilization Management Phone Line Report (see Section 2.30.12.1.1)

160. 24/7 Nurse Triage Line Report (see Section 2.30.12.1.2)

161. ED Assistance Tracking Report (see Section 2.30.12.1.3)

162. Translation/Interpretation Services Report (see Section 2.30.12.3)

163. Provider Satisfaction Survey Report (see Section 2.30.12.4)

164. Provider Complaints Report (see Section 2.30.12.5)

165. Member Complaints Report (see Section 2.30.13)

166. Fraud and Abuse Activities Report (see Section 2.30.14.1)

167. Policies in compliance with Section 1902(a)(68) of the Social Security Act (see Section 2.30.14.3)

168. Recovery and Cost Avoidance Report (see Section 2.30.15.1.1)

169. Other Insurance Report (see Section 2.30.15.1.2)

170. Medical Loss Ratio (MLR) Report (see Section 2.30.15.3.1)

171. Ownership and Financial Disclosure Report (see Section 2.30.15.3.2)

172. Annual audit plan (see Section 2.30.15.3.3)

173. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.15.4.1)

174. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.15.4.2)

175. Annual Financial Report (to TDCI) (see Section 2.30.15.4.3)

176. Quarterly Financial Report (to TDCI) (see Section 2.30.15.4.4)

177. Audited Financial Statements (to TDCI) (see Section 2.30.15.4.5)

178. Claims Payment Accuracy Report (see Section 2.30.16.1)

179. EOB Report (see Section 2.30.16.2)

180. Claims Activity Report (see Section 2.30.16.3)

181. CHOICES Cost Effective Alternatives Report (see Section 2.30.16.4)

182. Systems Refresh Plan (see Section 2.30.17.1)

183. Encounter Data Files (see Section 2.30.17.2)

184. Electronic version of claims paid reconciliation (see Section 2.30.17.3)

185. Information and/or data to support encounter data submission (see Section 2.30.17.4)

186. Systems Availability and Performance Report (see Section 2.30.17.5)

187. Business Continuity and Disaster Recovery Plan (see Section 2.30.17.6)

188. Reports on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee (see Section 2.30.18.1)

189. Report on the Activities of the CONTRACTOR's CHOICES Advisory Group (see Section 2.30.18.2)

190. Subcontracted claims processing report (see Section 2.30.19.1)

191. Security Incident Report (see Section 2.30.20)

192. Non-discrimination policy (see Section 2.30.21.1)

193. Summary Listings of Servicing Providers (see Section 2.30.21.2)

194. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.21.3)

195. Non-Discrimination Compliance Report (see Section 2.30.21.4)

196. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1

197. Disclosure of conflict of interest (see Section 2.30.22.1)

198. Attestation Re: Personnel Used in Contract Performance (see Section 2.30.22.2)

199. Return of funds in accordance with Section 3.14.5

200. Termination plan in accordance with Section 4.4.8.2.8

201. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI

Amendment Number 5 (cont.)

124. Exhibit M of Attachment IX shall be deleted and replaced as follows:

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT PHONE LINE REPORT

MCO Name:_____

Report Submission Date:_____

Reporting Quarter:_____

		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Nurse Triage Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Provider Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Utilization Management Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			

125. Attachment XI, NEMT Requirements, Section A.19.6.4.2 shall be amended by deleting the reference to "Section A.14.4" and replacing it with the reference "Section A.14.3".

126. Attachment XI, NEMT Requirements, Exhibit B, Item 4 shall be amended by deleting the text "/BHO".

127. Attachment XII, CAPITATION RATES, shall be amended by deleting and replacing the existing Exhibit C and adding a new Exhibit D to read as follows:

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

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

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

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

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

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 March 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: 3/5/10

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY: _____
Eric H. Paul
Chief Executive Officer, TennCare

DATE: 2-26-10

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: 4/14/10

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
Justin P. Wilson
Comptroller

DATE: APR 14 2010

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
318.66-051	FA-07-16937-04
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	June 30, 2010	subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010	$195,060,989.00	$587,844,846.00			$ 782,905,835.00
					$ -
					$ -
TOTAL:	$ 765,813,353.00	$ 1,590,930,518.00	$ -	$ -	**$ 2,356,743,871.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009	$ 699,483,574.00	
2010		$782,905,835.00
		$ -
TOTAL:	$ 1,573,838,036.00	$ 782,905,835.00
End Date	June 30, 2010	

State Agency Fiscal Contact & Telephone #

Scott Pierce 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 only for base contracts with contract # prefix: FA or GR)

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government (eg,ID,GG,GU) [ ] Other

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

RECEIVED
SEP 8 2009
MANAGEMENT SERVICES

OCR
AUG 25 2009
RECEIVED

AMENDMENT NUMBER 4

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

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. The preamble shall be amended to add references to long-term care services and delete references to "State Onlys and Judicials" and shall read as follows:

This Agreement is entered into by and between THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" or "State" and UnitedHealthcare Plan of the River Valley, Inc., hereinafter referred to as "the CONTRACTOR".

WHEREAS, the purpose of this Agreement is to assure the provision of quality physical health, behavioral health, and long-term care services while controlling the costs of such services;

WHEREAS, consistent with waivers granted by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to Health Maintenance Organizations (HMOs), referred to as Managed Care Organizations or MCOs, for rendering or arranging necessary physical health, behavioral health, and long-term care services to persons who are enrolled in Tennessee's TennCare program;

WHEREAS, the Tennessee Department of Finance and Administration is the state agency responsible for administration of the TennCare program and is authorized to contract with MCOs for the purpose of providing the services specified herein for the benefit of persons who are eligible for and are enrolled in the TennCare program; and

WHEREAS, the CONTRACTOR is a Managed Care Organization as described in the 42 CFR Part 438, is licensed to operate as an HMO in the State of Tennessee, has met additional qualifications established by the State, is capable of providing or arranging for the provision of covered services to persons who are enrolled in the TennCare

program for whom it has received prepayment, is engaged in said business, and is willing to do so upon and subject to the terms and conditions hereof;

NOW, THEREFORE, in consideration of the mutual promises contained herein the parties have agreed and do hereby enter into this Agreement according to the provisions set forth herein:

2. Section 1 shall be deleted in its entirety and replaced with the following:

SECTION 1 - DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Agreement shall be given the meaning used in TennCare rules and regulations. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Agreement, the specific language in Sections 2 through 4 of this Agreement shall govern.

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

1. Meeting general requirements in Section 2.2;

2. Enrollment and disenrollment in accordance with Section 2.4 and 2.5;

3. Additional services and use of incentives in Section 2.6.6;

4. Health education and outreach in Section 2.7.4;

5. Meeting requirements for coordination of services specified in Section 2.9, including care coordination for CHOICES members and the CONTRACTOR's electronic visit verification system except as otherwise provided in Section 3;

6. Establishing and maintaining a provider network in accordance with the requirements specified in Section 2.11, Attachments III, IV and V;

7. Utilization Management as specified in Section 2.14;

8. Quality Management and Quality Improvement activities as specified in Section 2.15;

9. Production and distribution of Member Materials as specified in Section 2.17;

10. Customer service requirements in Section 2.18;

11. Complaint and appeals processing and resolution in accordance with Section 2.19;

12. Determination of recoveries from third party liability resources in accordance with Section 2.21.4;

13. Claims Processing in accordance with Section 2.22;

14. Maintenance and operation of Information Systems in accordance with Section 2.23;

15. Personnel requirements in Section 2.29;

16. Production and submission of required reports as specified in Section 2.30;

17. Administration of this Agreement in accordance with policies and procedures;

18. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;

19. Premium tax; and

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

Adult Protective Services (APS) – An office within the Tennessee Department of Human Services that investigates reports of abuse, neglect (including self-neglect) or financial exploitation of vulnerable adults. APS staff assess the need for protective services and provide services to reduce the identified risk to the adult.

Adverse Action – Any action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits.

Affiliate – Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the CONTRACTOR.

Appeal Procedure – The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rules and regulations and any and all applicable court orders and consent decrees.

Area Agency on Aging and Disability (AAAD) – The agency designated by the Tennessee Commission on Aging and Disability (TCAD) to develop and administer a comprehensive and coordinated community based system in, or serving, a defined planning and service area.

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.

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 except for behavioral services for Priority enrollees.

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

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

Benefits – The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare enrollees enrolled in the CONTRACTOR's MCO pursuant to this Agreement.

Bureau of TennCare – The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare program. For the purposes of this Agreement, Bureau of TennCare shall mean the State of Tennessee and its representatives.

Business Day – Monday through Friday, except for State of Tennessee holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate various aspects of health care.

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 and Priority Add-on 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 and priority add-on rate.

Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in this Agreement and meets the qualifications specified in Section 2.9.6.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Agreement and in accordance with Section 2.9.6.

Care Coordination Unit – A specific group of staff within the MCO's organization dedicated to CHOICES that is comprised of care coordinators and care coordinator supervisors and which may also include care coordination teams.

Caregiver – For purposes of CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in

providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or for consumer direction of HCBS.

CEA – Cost Effective Alternative (see Section 2.6.5 of this Agreement).

Centers of Excellence (COE) for AIDS – Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare enrollees with HIV or AIDS.

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

CFR – Code of Federal Regulations.

Child Protective Services (CPS) – A program division of the Tennessee Department of Children's Services whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
   Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

2. Group 2
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

3. Group 3
   Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of HCBS, are "at-risk" for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations. Group 3 will not be included in CHOICES on the date of CHOICES implementation. TENNCARE intends to include CHOICES Group 3 on January 1, 2011. TENNCARE will notify the CONTRACTOR at least sixty (60) days prior to the proposed date for including Group 3 in CHOICES. As of the date specified in that notice, the CONTRACTOR shall accept members in CHOICES Group 3 and shall implement all of the requirements in this Agreement that are applicable to CHOICES Group 3.

CHOICES Implementation Date – The date, as determined by TENNCARE, when the CONTRACTOR shall begin providing long-term care services to CHOICES members.

CHOICES Member – A member who has been enrolled by TENNCARE into CHOICES.

Clean Claim – A claim received by the CONTRACTOR for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CONTRACTOR.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

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

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

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

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

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

CMS – Centers for Medicare & Medicaid Services.

Community-Based Residential Alternatives to Institutional Care (Community-Based Residential Alternatives) – Residential services that offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

Complaint – A written or verbal expression of dissatisfaction from a member about an action taken by the CONTRACTOR or service provider other than an adverse action. The CONTRACTOR shall not treat anything as a complaint that falls within the definition of adverse action.

Contract Provider – A provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide covered services.

Consumer – Except when used regarding consumer direction of HCBS, an individual who uses a mental health or substance abuse service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES member participating in consumer direction of HCBS or his/her representative to provide one or more eligible HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of HCBS – The opportunity for a CHOICES member assessed to need specified types of HCBS including attendant care, personal care, homemaker, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including HCBS, home health, and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy.

Covered Services – See Benefits.

CRA – Contractor Risk Agreement; also referred to as "Agreement."

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

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

Group 2 - Persons with Severe Mental Illness (SMI)

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

Group 4 - Persons with Mild or Moderate Mental Disorder

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

Days – Calendar days unless otherwise specified.

Dental Benefits Manager (DBM) – An entity responsible for the provision and administration of dental services, as defined by TENNCARE.

DHHS – United States Department of Health and Human Services.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the enrollment file furnished by TENNCARE to the CONTRACTOR.

Electronic Visit Verification (EVV) System – An electronic system into which provider staff and consumer-directed workers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program. As it relates to CHOICES a person is eligible to receive CHOICES benefits only if he/she has been enrolled in CHOICES by TENNCARE.

Emergency Medical Condition – A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also).

Enrollment – The process by which a TennCare enrollee becomes a member of the CONTRACTOR's MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

Essential Hospital Services – Tertiary care hospital services to which it is essential for the CONTRACTOR to provide access. Essential hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

Evidence-Based Practice – A clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness; specifically, the evidence-based practices recognized by the Substance Abuse and

Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS).

Expenditure Cap – The annual limit on expenditures for HCBS, excluding home modifications, for CHOICES members in CHOICES Group 3. The expenditure cap is $15,000.

Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the CONTRACTOR or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractor or provider to provide services on behalf of the CONTRACTOR.

Fee-for-Service – A method of making payment for health services based on a fee schedule that specifies payment for defined services.

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps CHOICES members participating in consumer direction of HCBS. The FEA provides both financial administrative services and supports brokerage to CHOICES members participating in consumer direction of HCBS.

FQHC – Federally Qualified Health Center.

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

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

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

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

Grand Rounds – As used with respect to CHOICES members residing in a nursing facility, a planned quarterly meeting between nursing facility staff and MCO staff, including, at minimum, the care coordinator(s) assigned to residents of the facility conducted in order to: (1) address issues or concerns regarding members who have experienced a potential significant change in needs or circumstances or about whom the nursing facility or MCO has concerns (not necessarily all members who are residents of the facility); (2) identify any change in services or interventions for the members, including but not limited to changes in the members' plans of care or supplements to the members' plans of care; and (3) facilitate access to and coordination of physical health and/or behavioral health services needed by the members and to ensure the proper

management of the members' acute and/or chronic conditions. At least two of the quarterly Grand Rounds per year shall be conducted on-site in the facility.

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

Health Maintenance Organization (HMO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 32.

HIPAA – Health Insurance Portability and Accountability Act.

Home and Community-Based Services (HCBS) – Services not covered by Tennessee's Title XIX state plan that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). HCBS does not include home health or private duty nursing services.

Hospice – Services as described in TennCare rules and regulations and 42 CFR Part 418, which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

Information System(s) (Systems) – A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Immediate Eligibility – A mechanism by which the State can, based on a preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered HCBS, be determined by TENNCARE to meet nursing facility level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES Group 2 based on review of the financial information provided by the applicant. Immediate eligibility shall only be for specified HCBS (no other covered services) and for a maximum of forty-five (45) days.

Intervention - An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

Law – Statutes, codes, rules, regulations, and/or court rulings.

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

Long-Term Care – The services of a nursing facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community-Based Services (HCBS).

Long-Term Care Ombudsman Program – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Tennessee Commission on Aging and Disability (TCAD).

Managed Care Organization (MCO) – An HMO that participates in the TennCare program.

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

Marketing – Any communication, from the CONTRACTOR to a TennCare enrollee who is not enrolled in the CONTRACTOR's MCO, that can reasonably be interpreted as intended to influence the person to enroll in the CONTRACTOR's MCO, or either to not enroll in, or to disenroll from, another MCO's TennCare product.

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health, behavioral health, and/or long-term care services to members pursuant to the following listed Sections of the Agreement:

    a. Section 2.6.1, CONTRACTOR Covered Benefits;

    b. Section 2.6.4, Second Opinions;

    c. Section 2.6.5, Use of Cost Effective Alternative Services;

    d. Section 2.7, Specialized Services except TENNderCare member and provider outreach and education, health education and outreach and advance directives;

    e. Capitated payment to licensed providers;

    f. Medical services directed by TENNCARE or an Administrative Law Judge; and

    g. Net impact of reinsurance coverage purchased by the CONTRACTOR.

2. Medical Expenses do not include:

    a. 2.6.2 TennCare Benefits Provided by TENNCARE;

    b. 2.6.7 Cost sharing for services;

    c. 2.10 Services Not Covered;

    d. Services eligible for reimbursement by Medicare; or

e. The activities described in or required to be conducted in Attachments II through X, which are administrative costs.

3. Medical expenses shall be net of any TPL recoveries or subrogation activities.

4. This definition does not apply to NAIC filings.

Medical Loss Ratio (MLR) – The percentage of capitation payment received from TENNCARE that is used to pay medical expenses.

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

Member – A TennCare enrollee who enrolls in the CONTRACTOR's MCO under the provisions of this Agreement (see Enrollee, also).

Member Month – A month of coverage for a TennCare enrollee enrolled in the CONTRACTOR's MCO.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

NAIC – National Association of Insurance Commissioners.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

Non-Contract Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

Office of the Comptroller of the Treasury – The Comptroller of the Treasury is a State of Tennessee constitutional officer elected by the General Assembly for a term of two years. Statutes prescribe the comptroller's duties, the most important of which relate to audit of state and local government entities and participation in the general financial and administrative management of state government.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

One-Time HCBS – In-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

Ongoing HCBS – Community-based residential alternatives, personal care, attendant care, homemaker services, home-delivered meals, and/or adult day care.

PASRR – Preadmission Screening and Resident Review.

Patient Liability – The amount of an enrollee's income, as determined by DHS, to be collected each month to help pay for the enrollee's long-term care services.

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member's condition.

Prepaid Limited Health Service Organization (PLHSO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 51.

Presumptive Eligibility – An established period of time (45 days) during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete an application for Medicaid in order to stay on the program.

Primary Care Physician – A physician responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is generally a physician who has limited his/her practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Geriatrician, or Family Practitioner. However, as provided in Section 2.11.2.4 of this Agreement, in certain circumstances other physicians may be primary care physicians if they are willing and able to carry out all PCP responsibilities in accordance with this Agreement.

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

Prior Authorization – The act of authorizing specific services or activities before they are rendered or occur.

Priority Add-on Rate – The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement as compensation for the provision of behavioral health services for Priority enrollees.

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

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Protected Health Information (PHI) – Identifiable health information as defined in 45 CFR Part 160 and Part 164.

Provider – An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Provider does not include consumer-directed workers (see Consumer-Directed Worker); nor does provider include the FEA (see Fiscal Employer Agent).

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between the CONTRACTOR and a provider or between the CONTRACTOR's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the CONTRACTOR's members.

Quality Management/Quality Improvement (QM/QI) – The development and implementation of strategies to assess and improve the performance of a program or organization on a continuous basis. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

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

Representative – In general, for CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care planning and implementation and to speak and make decisions on the member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns. As it relates to consumer direction of HCBS, a person who meets the qualifications specified in Section 2.9.7 of this Agreement, is authorized by the member to direct and manage the consumer's worker(s), and signs a representative agreement.

Representative Agreement – The agreement between a CHOICES member electing consumer direction of HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

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

Risk Agreement – An agreement signed by a member who will receive HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. See Section 2.9.6 of this Agreement for related requirements.

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

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Final Rule adopting Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164.

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

1. Person under the age of 18; and

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

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

Service Agreement – The agreement between a CHOICES member electing consumer direction of HCBS (or the member's representative) and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing HCBS that was not initiated by a member, including a late visit that was not remedied within the timeframe specified by TENNCARE.

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

1. Age 18 and over; and

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

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

Shall – Indicates a mandatory requirement or a condition to be met.

Span of Control – Information systems and telecommunications capabilities that the CONTRACTOR itself operates or for which it is otherwise legally responsible according to this Agreement. The CONTRACTOR's span of control also includes Systems and telecommunications capabilities outsourced by the CONTRACTOR.

Specialty Services – Includes Essential Hospital Services and specialty physician services.

SSA – Social Security Administration.

SSI – Supplemental Security Income.

Start Date of Operations – The date, as determined by TENNCARE, when the CONTRACTOR shall begin providing services to members.

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Bureau of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General..

Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, disease management) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Subcontractor – Any organization or person who provides any function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

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

System Unavailability – As measured within the CONTRACTOR's information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

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

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
   Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).

2. Target Population Group 3: At Risk of a (SED)
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.

3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

TCA – Tennessee Code Annotated.

TENNCARE – TENNCARE shall have the same meaning as "State."

TennCare or TennCare Program – The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare's managed care delivery system.

TennCare Medicaid Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in TennCare rules and regulations.

TennCare Select – TennCare Select is a statewide MCO whose risk is backed by the State of Tennessee. TennCare Select was created to serve as a backup if other MCOs failed or there was inadequate MCO capacity and to be the MCO for certain populations, including children in state custody and children eligible for SSI. Children eligible for SSI may opt out of TennCare Select and enroll in another MCO.

TennCare Standard Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver and the TennCare rules and regulations.

TENNderCare – Tennessee's EPSDT program; see EPSDT.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

Tennessee Department of Children's Services (DCS) – The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.

Tennessee Department of Commerce and Insurance (TDCI) – The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

Tennessee Department of Finance and Administration (F&A) – The state agency that oversees all state spending and acts as the chief corporate office of the state. It is the single state Medicaid agency. The Bureau of TennCare is a division of the Tennessee Department of Finance and Administration.

Tennessee Department of Health (DOH) – The state agency having the statutory authority to provide for health care needs in Tennessee.

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency. DHS is responsible for TennCare eligibility determinations (other than presumptive eligibility and SSI).

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) – The state agency having the authority to provide care for persons with mental illness, substance abuse, and/or developmental disabilities. For the purposes of this Agreement, TDMHDD shall mean the State of Tennessee and its representatives.

Third Party Liability (TPL) – Any amount due for all or part of the cost of medical, behavioral health, or long-term care services from a third party.

Third Party Resource – Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of health care of the enrollee.

Transition Allowance – A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

USC – United States Code.

Vital MCO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be available in Spanish.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Worker – See Consumer-Directed Worker.

3. Section 2.1.2 shall be amended by adding a new Section 2.1.2.4 and renumbering existing subparts accordingly, including any references thereto.

2.1.2.4 Prior to the date of implementation of CHOICES in the Grand Region covered by this Agreement, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that it is able to meet all requirements related to the CHOICES program. The CONTRACTOR shall cooperate in this "readiness review," which may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all requirements of the Agreement related to the CHOICES program, as determined by TENNCARE. Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR. TENNCARE will not enroll members into the CONTRACTOR's CHOICES program until TENNCARE has determined that the CONTRACTOR is able to meet all requirements related to the CHOICES program.

4. Sections 2.3 shall be deleted in its entirety and replaced with the following:

2.3 ELIGIBILITY FOR TENNCARE

2.3.1 **Overview**

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

2.3.2 **Eligibility Categories**

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

2.3.2.1 <u>TennCare Medicaid</u>

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

2.3.2.2 <u>TennCare Standard</u>

TennCare Standard includes the Standard Spend Down (SSD) population, the CHOICES 217-Like HCBS Group, and an expanded population of children. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.3 **TennCare CHOICES Groups**

As specified in Section 2.6.1.5, in order to receive covered long-term care services, a member must be enrolled by TENNCARE into one of the CHOICES Groups (as defined in Section 1).

2.3.4 **TennCare Applications**

The CONTRACTOR shall not cause applications for TennCare to be submitted. However, as provided in Section 2.9.6.3, the CONTRACTOR shall facilitate members' eligibility determination for CHOICES enrollment.

2.3.5 **Eligibility Determination and Determination of Cost Sharing**

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

2.3.6 **Eligibility for Enrollment in an MCO**

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

5. Section 2.4 shall be deleted in its entirety and replaced with the following:

2.4 ENROLLMENT IN AN MCO

2.4.1 **General**

TENNCARE is solely responsible for enrollment of TennCare enrollees in an MCO.

2.4.2 **Authorized Service Area**

2.4.2.1 Grand Region

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

2.4.2.2 CONTRACTOR's Authorized Service Area

The CONTRACTOR is authorized under this Agreement to serve enrollees who reside in the Grand Region(s) specified below:

__East Grand Region X Middle Grand Region __West Grand Region

2.4.3 **Maximum Enrollment**

2.4.3.1 The CONTRACTOR agrees to accept enrollment in the CONTRACTOR's MCO of up to seventy percent (70%) of the eligible population in the applicable Grand

Region. TENNCARE shall determine and notify the CONTRACTOR of the number of eligibles in the applicable Grand Region and the CONTRACTOR's maximum enrollment limit, which shall be approximately seventy percent (70%) of the eligible population in the applicable Grand Region.

2.4.3.2 TENNCARE shall establish an enrollment threshold for the CONTRACTOR that will equal approximately ninety percent (90%) of the maximum enrollment limit established in Section 2.4.3.1 above. This enrollment threshold may be adjusted by TENNCARE at its discretion.

2.4.3.3 Once the CONTRACTOR's enrollment threshold is met, TENNCARE may discontinue default assignment of enrollees to the CONTRACTOR's MCO. Enrollees who select the CONTRACTOR or whose family members are enrolled in the CONTRACTOR's MCO shall continue to be enrolled in the CONTRACTOR's MCO until the maximum enrollment limit established in Section 2.4.3.1 above is met.

2.4.3.4 Both TENNCARE and the CONTRACTOR recognize that management of the CONTRACTOR's maximum enrollment limit and enrollment threshold within exact limits may not be possible. In the event enrollment in the CONTRACTOR's MCO exceeds the maximum enrollment limit, TENNCARE may reduce enrollment in the CONTRACTOR's MCO based on a plan established by TENNCARE that provides appropriate notice to the CONTRACTOR, allows appropriate choice of MCOs for enrollees, and meets the objectives of the TennCare program.

2.4.3.5 The establishment of a maximum enrollment limit and/or of an enrollment threshold does not obligate the State to enroll a certain number of TennCare enrollees in the CONTRACTOR's MCO and does not create in the CONTRACTOR any rights, interests or claims of entitlement to enrollment. The CONTRACTOR's actual enrollment level will be determined through the MCO selection and assignment process described in Section 2.4.4 below.

2.4.3.6 Upon the request of TENNCARE, the CONTRACTOR shall demonstrate to the satisfaction of TENNCARE it has the capacity to serve the number of enrollees in the maximum enrollment limit.

2.4.4 MCO Selection and Assignment

2.4.4.1 General

TENNCARE shall enroll individuals determined eligible for TennCare and eligible for enrollment in an MCO that is available in the Grand Region in which the enrollee resides. Enrollment in an MCO may be the result of an enrollee's selection of a particular MCO or assignment by TENNCARE. Enrollment in the CONTRACTOR's MCO is subject to the CONTRACTOR's maximum enrollment limit and threshold (see Section 2.4.3) and capacity to accept additional members.

2.4.4.2 Current TennCare Enrollees

TennCare enrollees who are known to be eligible for enrollment with the CONTRACTOR as of the start date of operations (defined in Section 1 of this Agreement) and residing in the Grand Region served by the CONTRACTOR shall be assigned by TENNCARE to the MCOs serving the Grand Region in accordance with the process described in Section 2.4.4.6 below. Except as otherwise provided in Section 2.4.4, this includes enrollees currently enrolled in another MCO, including TennCare Select.

2.4.4.3 New TennCare Enrollees

2.4.4.3.1 Except as otherwise provided in this Agreement, all non-SSI applicants shall be required at the time of their application to select an MCO other than TennCare Select from those MCOs available in the Grand Region where the applicant resides. If the applicant does not select an MCO, the person will be assigned to an MCO by the State in accordance with Section 2.4.4.6.

2.4.4.3.2 Adults eligible for TennCare as a result of being eligible for SSI benefits will be assigned to an MCO (other than TennCare Select) by the State.

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

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

2.4.4.4 Children in State Custody

TennCare enrollees who are children in the custody of the Department of Children's Services (DCS) will be enrolled in TennCare Select. When these enrollees exit state custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled from TennCare Select. After disenrollment from TennCare Select, if the enrollee has a family member in an MCO (other than TennCare Select) he/she will be enrolled in that MCO. Otherwise, the enrollee will be given the opportunity to select another MCO. If the enrollee does not select another MCO, he/she will be assigned to an MCO (other than TennCare Select) using the default logic in the auto assignment process (see Section 2.4.4.6 below).

2.4.4.5 Enrollment in MCO Other than the MCO Selected

In certain circumstances, if an enrollee requests enrollment in a particular MCO, the enrollee may be assigned by the State to an MCO other than the one that he/she requested. Examples of circumstances when an enrollee would not be enrolled in the requested MCO include, but are not limited to, such factors as the enrollee does not reside in the Grand Region covered by the requested MCO, the enrollee has other family members already enrolled in a different MCO, the MCO is closed to new TennCare enrollment, or the enrollee is a member of a population that is to be enrolled in a specified MCO as defined by TENNCARE (e.g., children in the custody of the Department of Children's Services are enrolled in TennCare Select).

2.4.4.6 Auto Assignment

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

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

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

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

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

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

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

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

2.4.4.7 Non-Discrimination

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

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

2.4.4.8 Family Unit

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

2.4.5 **Effective Date of Enrollment**

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

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

2.4.5.2 Ongoing Enrollment

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

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations. Although the enrollee is not a member of the CONTRACTOR's MCO prior to the start date of operations, the CONTRACTOR shall be responsible for the payment of claims incurred by the enrollee during the period of eligibility prior to the start date of operations as specified in Section 3.7.1.2.1.

2.4.5.4 TENNCARE will be responsible for the payment of claims for long-term care services provided to a CHOICES member during the member's period of TennCare eligibility prior to the implementation of CHOICES in the Grand Region covered by this Agreement.

2.4.5.5 Enrollment Prior to Notification

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

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

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

enrollment/eligibility precedes the start date of operations, payment shall be made in accordance with Section 3.7.1.2.1. TENNCARE will be responsible for the payment of claims for long-term care services provided to a CHOICES member during the member's period of TennCare eligibility prior to the implementation of CHOICES in the Grand Region covered by this Agreement.

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

2.4.6 **Eligibility and Enrollment Data**

2.4.6.1 The CONTRACTOR shall receive, process, and update enrollment files from TENNCARE. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE.

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

2.4.7 **Enrollment Period**

2.4.7.1 General

2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered physical health and behavioral health services provided to enrollees during their period of enrollment with the CONTRACTOR. The CONTRACTOR shall be responsible for the provision and costs of covered long-term care services provided to CHOICES members as of the date of CHOICES implementation.

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

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

2.4.7.2 Changing MCOs

2.4.7.2.1 *45-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), enrollees shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCOs. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or remain with TennCare Select.

2.4.7.2.2 *Annual Choice Period*

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

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

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

2.4.7.2.3 *Appeal Based on Hardship Criteria*

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

2.4.7.2.4 *Additional Reasons for Disenrollment*

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

2.4.7.3 Member Moving out of Grand Region

The CONTRACTOR shall be responsible for the provision and cost of all covered services for any member moving outside the CONTRACTOR's Grand Region until the member is disenrolled by TENNCARE. TENNCARE shall continue to make payments to the CONTRACTOR on behalf of the enrollee until such time as the enrollee is enrolled in another MCO or otherwise disenrolled by TENNCARE (e.g., enrollee is terminated from the TennCare program). TENNCARE shall notify the CONTRACTOR promptly upon enrollment of the enrollee in another MCO.

2.4.8 **Transfers from Other MCOs**

2.4.8.1 The CONTRACTOR shall accept enrollees (enrolled or pending enrollment) from any MCO in the CONTRACTOR's service area as authorized by TENNCARE. The transfer of membership may occur at any time during the year. No enrollee from another MCO shall be transferred retroactively to the CONTRACTOR except as specified in Section 2.4.9. Except as provided in Section 2.4.9, the CONTRACTOR shall not be responsible for payment of any covered services incurred by enrollees transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

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

2.4.8.3 To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a Grand Region of the impending failure of one of the MCOs serving

the Grand Region; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to accept enrollees from failed MCOs.

2.4.9 **Enrollment of Newborns**

2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.

2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.

2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:

2.4.9.3.1 Disenroll the newborn from the incorrect MCO;

2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO;

2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and

2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.

2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the capitation payment to the correct MCO.

2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the

second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

2.4.10 **Information Requirements Upon Enrollment**

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, a provider directory and an identification card. In addition, the CONTRACTOR shall provide CHOICES members with CHOICES member education materials (see Section 2.17.7).

6. Section 2.5.2 shall be amended by adding a new Section 2.5.2.3 and renumbering existing subparts accordingly, including any references thereto.

2.5.2.3 A request by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is approved by TENNCARE, and the member is enrolled in another MCO;

7. Section 2.5.5 shall be amended by adding "from an MCO" to the end of the heading to read as follows:

2.5.5 **Effective Date of Disenrollment from an MCO**

8. Section 2.6 shall be deleted in its entirety and replaced with the following:

2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS

2.6.1 **CONTRACTOR Covered Benefits**

2.6.1.1 The CONTRACTOR shall cover the physical health, behavioral health and long-term care services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.7.2 and Attachment I.

2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:

2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section 2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.

2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section 2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the CONTRACTOR may either route calls to another entity or conduct "warm transfers," but the CONTRACTOR shall not require an enrollee to call a separate number.

2.6.1.2.3 As required in Sections 2.9.5 and 2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term care services and ensure collaboration among physical health, behavioral health, and long-term care providers. For CHOICES members, the member's care coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term care services, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term care providers.

2.6.1.2.4 Each of the CONTRACTOR's disease management programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide MCO case management to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide MCO case management to enrollees with co-morbid physical health and behavioral health conditions. If a member with co-morbid physical and behavioral health conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's MCO case managers collaborate and communicate in an effective and ongoing manner. As required in Section 2.9.6.1.8 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, MCO case management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's case management program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its case management activities per requirements in Section 2.30.6.1.

2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services, behavioral health and/or long-term care services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.

2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section 2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's senior executive psychiatrist who oversees behavioral health activities (see Section 2.29.1.3.4 of this Agreement) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Section 2.29.1.3.5 of this Agreement) for all issues pertaining to the CHOICES program.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** As medically necessary, including rehabilitation hospital facility.
Outpatient Hospital Services		As medically necessary.
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.

SERVICE		BENEFIT LIMIT
TENNderCare Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.6.
Preventive Care Services		As described in Section 2.7.5.
Lab and X-ray Services		As medically necessary.
Hospice Care		As medically necessary. Shall be provided by a Medicare-certified hospice.
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager.** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.
Vision Services		**Medicaid/Standard Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENNderCare requirements.

SERVICE		BENEFIT LIMIT
Home Health Care		**Medicaid /Standard Eligible, Age 21 and older:** Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).
Durable Medical Equipment (DME)		As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.
Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency		Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services

SERVICE		BENEFIT LIMIT
Ambulance Transportation)		shall be provided in accordance with federal law and the Bureau of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18). The CONTRACTOR is not responsible for providing NEMT to HCBS, including services provided through a 1915(c) waiver program for persons with mental retardation and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service. If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.

SERVICE		BENEFIT LIMIT
Renal Dialysis Services		As medically necessary.
Private Duty Nursing		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Speech Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Occupational Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

SERVICE		BENEFIT LIMIT
Physical Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Organ and Tissue Transplant And Donor Organ Procurement		**Medicaid/Standard Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery		Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE		BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)		As medically necessary.
24-hour Psychiatric Residential Treatment		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services)		As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits[1]		**Medicaid/Standard Eligible, Age 21 and older:** Limited to ten (10) days detox, $30,000 in medically necessary lifetime benefits unless otherwise described in the 2008 Mental Health Parity Act as determined by TENNCARE. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Mental Health Case Management		As medically necessary.
Psychiatric-Rehabilitation Services		As medically necessary.
Behavioral Health Crisis Services		As necessary.
Lab and X-ray Services		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Same as for physical health (see Section 2.6.1.3 above).

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

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1).

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee's combined HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR's request to provide HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 For persons determined to be eligible for enrollment in Group 2 as a result of Immediate Eligibility (as defined in Section 1 of this Agreement), the CONTRACTOR shall provide a limited package of HCBS (personal care, attendant care, homemaker services, home-delivered meals, PERS, adult day care, and/or any other services as specified in TennCare rules and regulations) as identified through a needs assessment and specified in the plan of care. Upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, the CONTRACTOR shall authorize additional services in accordance with Section 2.9.6.2.5. For members residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.6.1.5.4 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	**Group 1**	**Group 2**	**Group 3**
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day)		X	X

Service and Benefit Limit	Group 1	Group 2	Group 3
Attendant care (up to 1080 hours per calendar year)		X	X
Homemaker services (up to 3 visits per week)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

2.6.1.5.5 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the cost neutrality cap for CHOICES Group 2 or the expenditure cap for Group 3. For CHOICES members in Group 2, the total cost of HCBS, home health care and private duty nursing shall not exceed a member's cost neutrality cap (as defined in Section 1 of this Agreement). For CHOICES members in Group 3, the total cost of HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section 1 of this Agreement).

2.6.1.5.6 CHOICES members may, pursuant to Section 2.9.7, choose to participate in consumer direction of HCBS and, at a minimum, hire, fire and supervise workers of eligible HCBS.

2.6.1.5.7 The CONTRACTOR shall monitor CHOICES members' receipt and utilization of long-term care services, identify CHOICES members who have not received long-term care services within a thirty (30) day period of time, and notify TENNCARE regarding these members pursuant to Section 2.30.10.5. TENNCARE will investigate to determine if the member should remain enrolled in CHOICES.

2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.5.8.1 A member in Group 2 or 3 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

2.6.1.5.8.2 A member in Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into his/her place of residence (Section 2.9.6);

2.6.1.5.8.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's plan of care; and

2.6.1.5.8.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section 2.6.7.2).

2.6.1.5.8.5 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TennCare.

2.6.2 **TennCare Benefits Provided by TENNCARE**

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

2.6.2.1 Dental Services

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

2.6.2.2 Pharmacy Services

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

2.6.2.3 ICF/MR Services and Alternatives to ICF/MR Services

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

2.6.3 **Medical Necessity Determination**

2.6.3.1 The CONTRACTOR may establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and TennCare rules and regulations. However, this requirement shall not limit the CONTRACTOR's ability to use medically appropriate cost effective alternatives in accordance with Section 2.6.5.

2.6.3.2 The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded (up to the applicable benefit limits on behavioral health and long-term care services provided in Section 2.6.1.4 and 2.6.1.5 above) when medically necessary based on a member's individual characteristics.

2.6.3.3 The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

2.6.3.4 The CONTRACTOR may deny services that are non-covered except as otherwise required by TENNderCare or unless otherwise directed to provide by TENNCARE and/or an administrative law judge.

2.6.3.5 All medically necessary services shall be covered for enrollees under twenty-one (21) years of age in accordance with TENNderCare requirements (see Section 2.7.6).

2.6.4 **Second Opinions**

The CONTRACTOR shall provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent and/or legally appointed representative. The second opinion shall be provided by a contracted qualified health care professional or the CONTRACTOR shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.

2.6.5 **Use of Cost Effective Alternative Services**

2.6.5.1 The CONTRACTOR shall be allowed to use cost effective alternative services, whether listed as covered or non-covered or omitted in Section 2.6.1 of this Agreement, when the use of such alternative services is medically appropriate and is cost effective. This may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation. The CONTRACTOR shall comply with TennCare policies and procedures. As provided in the applicable TennCare policies and procedures, services not listed in the TennCare policies and procedures must be prior approved in writing by TENNCARE.

2.6.5.2 For CHOICES members, the CONTRACTOR may choose to provide the following as a cost effective alternative to other covered services:

2.6.5.2.1 HCBS to CHOICES members who would otherwise receive nursing facility care. If a member meets categorical and financial eligibility requirements for enrollment in Group 2 and also meets the nursing facility level of care, as determined by TENNCARE, and would otherwise remain in or be admitted to a nursing facility (as determined by the CONTRACTOR and demonstrated to the satisfaction of TENNCARE), the CONTRACTOR may, at its discretion and upon TENNCARE written prior approval, offer that member HCBS as a cost effective alternative to nursing facility care (see Section 2.9.6.3.13). In this instance, TENNCARE will enroll the member receiving HCBS as a cost effective alternative to nursing facility services in Group 2, notwithstanding any enrollment target for Group 2 that has been reached.

2.6.5.2.2 HCBS to CHOICES members in Group 2 in excess of the benefit limits described in Section 2.6.1.5.4 as a cost effective alternative to nursing facility care or covered home health services.

2.6.5.2.3 HCBS to CHOICES members in Group 3 in excess of the benefit limits described in Section 2.6.1.5.4 as a cost effective alternative to covered home health services. Members in Group 3 do not meet nursing facility level of care and as such, HCBS in excess of benefit limits specified in Section 2.6.1.5.4 may not be offered as a cost effective alternative to nursing facility care.

2.6.5.2.4 Non-covered HCBS services to CHOICES members in Group 2 not otherwise specified in this Agreement or in applicable TennCare policies and procedures, upon written prior approval from TENNCARE.

2.6.5.2.5 For CHOICES members transitioning from a nursing facility to a community setting, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars ($2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items.

2.6.5.2.6 For CHOICES members in Groups 2 or 3, non-emergency medical transportation (NEMT) not otherwise covered by this Agreement.

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of HCBS includes all HCBS (whether otherwise covered or not covered) and other services that are offered as a cost effective alternative to nursing facility care, HCBS, or home health, including, as applicable, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

2.6.6 **Additional Services and Use of Incentives**

2.6.6.1 The CONTRACTOR shall not advertise any services that are not required by this Agreement other than those covered pursuant to Section 2.6.1 of this Agreement.

2.6.6.2 The CONTRACTOR shall not offer or provide any services other than services covered by this Agreement (see Section 2.6.1) or services provided as a cost effective alternative (see Section 2.6.5) of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in disease management programs.

2.6.7 **Cost Sharing and Patient Liability**

2.6.7.1 General

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

2.6.7.2 Patient Liability

2.6.7.2.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for CHOICES members in Group 1 via the eligibility/enrollment file. The CONTRACTOR shall delegate collection of patient liability to the nursing facility and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.2 In accordance with the involuntary discharge process, including notice and appeal (see Section 2.12.11.3), a nursing facility may refuse to continue providing services to a member who fails to pay his or her patient liability and for whom the nursing facility can demonstrate to the CONTRACTOR that it has made a good faith effort to collect payment.

2.6.7.2.3 If the CONTRACTOR is notified that a nursing facility is considering discharging a member (see Section 2.12.11.3), the CONTRACTOR shall work to find an alternate nursing facility willing to serve the member and document its efforts in the member's files.

2.6.7.2.4 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, the member shall be offered a choice of HCBS. If the member chooses HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding enrollment in Group 2 (Section 2.9.6.3).

2.6.7.2.5 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the CONTRACTOR determines that it cannot safely and effectively serve the member in the community and within the cost neutrality cap, the member declines to enroll in Group 2, or TENNCARE denies enrollment in Group 2, the CONTRACTOR may, pursuant to Section 2.6.1.5.8, request to no longer provide long-term care services to the member.

2.6.7.3 Preventive Services

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

2.6.7.4 Cost Sharing Schedule

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

2.6.7.5 Provider Requirements

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

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

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

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

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

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

9. Section 2.7 shall be deleted in its entirety and replaced with the following:

2.7 SPECIALIZED SERVICES

2.7.1 Emergency Services

2.7.1.1 Emergency services (as defined in Section 1 of this Agreement) shall be available twenty-four (24) hours a day, seven (7) days a week.

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.

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.

2.7.1.4 If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member. The CONTRACTOR shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility. If there is a disagreement between the treating facility and the CONTRACTOR concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending provider(s) actually caring for the member at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR, however, may establish arrangements with a treating facility whereby the CONTRACTOR may send one of its own providers with appropriate emergency room privileges to assume the attending provider's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

2.7.1.5 The CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. In such cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard regardless of final diagnosis.

2.7.1.6 When the member's PCP or the CONTRACTOR instructs the member to seek emergency services, the CONTRACTOR shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the member's condition meets the prudent layperson standard.

2.7.1.7 Once the member's condition is stabilized, the CONTRACTOR may require prior authorization for hospital admission or follow-up care.

2.7.2 **Behavioral Health Services**

2.7.2.1 <u>General Provisions</u>

2.7.2.1.1 The CONTRACTOR shall provide all behavioral health services as described in this Section, Section 2.6.1 and Attachment I.

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

2.7.2.1.3 The CONTRACTOR shall ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Providers included in this requirement are:

2.7.2.1.3.1 Community mental health agencies;

2.7.2.1.3.2 Case management agencies;

2.7.2.1.3.3 Psychiatric rehabilitation agencies;

2.7.2.1.3.4 Psychiatric and substance abuse residential treatment facilities; and

2.7.2.1.3.5 Psychiatric and substance abuse inpatient facilities.

2.7.2.1.4 Individualized treatment plans shall be completed within thirty (30) calendar days of the start date of service and updated every six (6) months, or more frequently as clinically appropriate. The treatment plans shall be developed, negotiated and agreed upon by the members and/or their support systems in face-to-face encounters and shall be used to identify the treatment needs necessary to meet the members' stated goals. The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.

2.7.2.2 <u>Psychiatric Inpatient Hospital Services</u>

2.7.2.2.1 The CONTRACTOR shall ensure that all psychiatric inpatient hospitals serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are accredited by the Joint Commission and accept voluntary and involuntary admissions.

2.7.2.3 <u>24-Hour Psychiatric Residential Treatment</u>

2.7.2.3.1 The CONTRACTOR shall ensure that 24-hour psychiatric residential treatment facilities (RTFs) serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.3.2 The CONTRACTOR shall ensure RTFs have the capacity to render short term crisis stabilization and long-term treatment and rehabilitation.

2.7.2.3.3 The CONTRACTOR shall ensure all RTFs meet local housing codes.

2.7.2.3.4 The CONTRACTOR shall ensure all RTFs are accredited by a State-recognized accreditation organization as required by 42 CFR 441.151.

2.7.2.4 Outpatient Mental Health Services

2.7.2.4.1 The CONTRACTOR shall ensure that outpatient mental health providers (including providers of intensive outpatient and providers of partial hospitalization services) serving children, youth and adults separate members by age and render developmental age appropriate services.

2.7.2.4.2 The CONTRACTOR shall ensure outpatient mental health providers are capable of rendering services both on and off site, as appropriate, depending on the services being rendered. On site services include, but are not limited to intensive outpatient services, partial hospitalization and many types of therapy. Off site services include but are not limited to intensive in home service for children and youth and home and community treatment for adults.

2.7.2.5 Inpatient, Residential & Outpatient Substance Abuse Services

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

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

2.7.2.6 Mental Health Case Management

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

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

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

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

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

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

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

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

2.7.2.7 Psychiatric Rehabilitation Services

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

2.7.2.8 Behavioral Health Crisis Services

2.7.2.8.1 *Entry into the Behavioral Health Crisis Services System*

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

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

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

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

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that the member has been evaluated by a crisis team. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to

an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

2.7.2.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

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

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

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

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

2.7.2.9 <u>Clinically Related Group (CRG) and Target Population Group (TPG) Assessments</u>

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

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

2.7.2.9.3 The CONTRACTOR shall ensure that its contract providers are trained and that there is sufficient capacity to perform CRG/TPG assessments. The CONTRACTOR shall require providers to use the CRG/TPG assessment form(s) as appropriate, prescribed by and in accordance with the policies of the state. The CRG/TPG assessments shall be subject to review and prior written approval by the State.

2.7.2.9.4 The CONTRACTOR shall identify persons in need of CRG/TPG assessments. The CONTRACTOR shall use the CRG/TPG assessments to identify persons who are SPMI or SED for reporting and tracking purposes, in accordance with the definitions contained in Section 1.

2.7.2.9.5 The CONTRACTOR shall ensure that providers who perform CRG/TPG assessments have been trained and authorized by the State to perform CRG/TPG assessments. Certified trainers shall be responsible for providing rater training within their agencies.

2.7.2.9.6 The CONTRACTOR shall reject all CRG/TPG assessments completed by unapproved raters. The CONTRACTOR shall report on rejected assessments as required in Section 2.30.4.6.

2.7.2.9.7 The CONTRACTOR shall conduct audits of CRG/TPG assessments for accuracy and conformity to state policies and procedures. The CONTRACTOR shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits and the results of these audits shall be reported as required in Sections 2.30.4.7 and 2.30.4.8.

2.7.2.10 Judicial Services

2.7.2.10.1 The CONTRACTOR shall provide covered court ordered behavioral health services to its members pursuant to court order(s). The CONTRACTOR shall furnish these services in the same manner as services furnished to other members.

2.7.2.10.2 The CONTRACTOR shall provide for behavioral health services to its members in accordance with state law. Specific laws employed include the following:

2.7.2.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release;

2.7.2.10.2.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (TCA 33-6-708);

2.7.2.10.2.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (TCA 33-6, Part 6);

2.7.2.10.2.4 Inpatient psychiatric examination for up to forty-eight (48) hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (TCA 33-3-607);

2.7.2.10.2.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (TCA 33-6, Part 2); and

2.7.2.10.2.6 Voluntary psychiatric hospitalization for persons with a severe impairment when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA 33-6, Part 3).

2.7.2.11 Mandatory Outpatient Treatment

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

2.7.2.11.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.7.2.11.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

2.7.3 **Self-Direction of Health Care Tasks**

The CONTRACTOR shall, as specified in TennCare rules and regulations, offer CHOICES members the option to direct and supervise a paid personal aide in the performance of health care tasks.

2.7.4 **Health Education and Outreach**

2.7.4.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities may include the following:

2.7.4.1.1 General physical, behavioral health and long-term care education classes;

2.7.4.1.2 Mental illness awareness programs and education campaigns with special emphasis on events such as National Mental Health Month and National Depression Screening Day;

2.7.4.1.3 Smoking cessation programs with targeted outreach for adolescents and pregnant women;

2.7.4.1.4 Nutrition counseling;

2.7.4.1.5 Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;

2.7.4.1.6 Prevention and treatment of substance abuse;

2.7.4.1.7 Self care training, including self-examination;

2.7.4.1.8 Need for clear understanding of how to take medications and the importance of coordinating all medications;

2.7.4.1.9 Understanding the difference between emergent, urgent and routine health conditions;

2.7.4.1.10 Education for members on the significance of their role in their overall health and welfare and available resources;

2.7.4.1.11 Education for caregivers on the significance of their role in the overall health and welfare of the member and available resources;

2.7.4.1.12 Education for members and caregivers about identification and reporting of suspected abuse and neglect;

2.7.4.1.13 Telephone calls, mailings and home visits to current members for the sole purpose of educating current members about services offered by or available through the CONTRACTOR's MCO; and

2.7.4.1.14 General activities that benefit the entire community (e.g., health fairs and school activity sponsorships).

2.7.4.2 The CONTRACTOR shall ensure that all health education and outreach activities are prior approved in writing by TENNCARE (see Section 2.17.1).

2.7.5 **Preventive Services**

2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities described in Section 2.6.7 of this Agreement (see TennCare rules and regulations for service codes).

2.7.5.2 Prenatal Care

2.7.5.2.1 The CONTRACTOR shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the appointment shall occur as required in Section 2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections 2.9.2.2 and 2.9.2.3 regarding prior authorization of prenatal care.

2.7.5.2.2 Failure of the CONTRACTOR to respond to a member's request for prenatal care by failing to identify a prenatal care provider to honor a request from a member, including a presumptively eligible member, (or from an PCP or patient advocate acting on behalf of a member) for a prenatal care appointment shall be considered a material breach of this Agreement.

2.7.5.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section 2.11.4 of this Agreement.

2.7.6 **TENNderCare**

2.7.6.1 General Provisions

2.7.6.1.1 The CONTRACTOR shall provide TENNderCare services to members under age twenty-one (21) in accordance with TennCare and federal requirements including TennCare rules and regulations, TennCare policies and procedures, 42 USC

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

2.7.6.1.2 The CONTRACTOR shall use the name "TENNderCare" in describing or naming the State's EPSDT program or services. This requirement is applicable for all policies, procedures and other material, regardless of the format or media. No other names or labels shall be used.

2.7.6.1.3 The CONTRACTOR shall have written policies and procedures for the TENNderCare program that include coordinating services with child-serving agencies and providers, providing all medically necessary TENNderCare services to all eligible members under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, and conducting outreach and education. The CONTRACTOR shall ensure the availability and accessibility of required health care resources and shall help members and their parents or legally appointed representatives use these resources effectively.

2.7.6.1.4 The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit).

2.7.6.1.5 The CONTRACTOR shall:

2.7.6.1.5.1 Require that providers provide TENNderCare services;

2.7.6.1.5.2 Require that providers make appropriate referrals and document said referrals in the member's medical record;

2.7.6.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TENNderCare services;

2.7.6.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers; and

2.7.6.1.5.5 Monitor provider compliance with required TENNderCare activities including compliance with proper coding.

2.7.6.1.6 The CONTRACTOR shall require that its contract providers notify the CONTRACTOR in the event a screening reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability to make an appropriate referral, the

CONTRACTOR shall secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation. In the event the failed referral is for dental services, the CONTRACTOR shall coordinate with the DBM to arrange for services.

2.7.6.1.7 The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary covered services regardless of whether the need for such services was identified by a provider who had received prior authorization from the CONTRACTOR or from a contract provider.

2.7.6.1.8 The CONTRACTOR shall have a tracking system to monitor each TENNderCare eligible member's receipt of the required screening, diagnosis, and treatment services. The tracking system shall have the ability to generate immediate reports on each member's TENNderCare status, reflecting all encounters reported more than sixty (60) days prior to the date of the report.

2.7.6.1.9 In the event that a member under sixteen (16) years of age is seeking behavioral health TENNderCare services and the member's parent(s), or legally appointed representative is unable to accompany the member to the examination, the CONTRACTOR shall require that its providers either contact the member's parent(s), or legally appointed representative to discuss the findings and inform the family of any other necessary health care, diagnostic services, treatment or other measures recommended for the member or notify the MCO to contact the parent(s), or legally appointed representative with the results.

2.7.6.2 <u>Member Education and Outreach</u>

2.7.6.2.1 The CONTRACTOR shall be responsible for outreach activities and for informing members who are under the age of twenty-one (21), or their parent or legally appointed representative, of the availability of TENNderCare services. All TENNderCare member materials shall be submitted to TENNCARE for written approval prior to distribution in accordance with Section 2.17.1 and shall be made available in accordance with the requirements specified in Section 2.17.2.

2.7.6.2.2 The CONTRACTOR shall have a minimum of six (6) "outreach contacts" per member per calendar year in which it provides information about TENNderCare to members. The minimum "outreach contacts" include: one (1) member handbook as described in Section 2.17.4, four (4) quarterly member newsletters as described in Section 2.17.5, and one (1) reminder notice issued before a screening is due. The reminder notice shall include an offer of transportation and scheduling assistance.

2.7.6.2.2.1 If the CONTRACTOR's TENNderCare screening rate is below ninety percent (90%), as determined in the most recent CMS 416 report, the CONTRACTOR shall conduct New Member Calls for all new members under the age of twenty-one (21) to inform them of TENNderCare services including assistance with appointment scheduling and transportation to appointments.

2.7.6.2.2.2 The CONTRACTOR shall have the ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency. At least one of the 6 outreach attempts identified above shall

advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

2.7.6.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TENNderCare screens are due.

2.7.6.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

2.7.6.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TENNderCare has used no services within a year and shall make two (2) reasonable attempts to re-notify such members about TENNderCare. The attempts must be different in format or message. One (1) of these attempts can be a referral to DOH for a screen. (These two (2) attempts are in addition to the one (1) attempt per quarter mentioned in Section 2.7.6.2.4 above.)

2.7.6.2.6 The CONTRACTOR shall require that providers have a process for documenting services declined by a parent or legally appointed representative or mature competent child, specifying the particular service was declined. This process shall meet all requirements outlined in Section 5320.2.A of the State Medicaid Manual.

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

2.7.6.2.8 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section 2.17.8 of this Agreement.

2.7.6.2.9 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TENNderCare services for their children. The CONTRACTOR shall offer TENNderCare services for the child when it is born.

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

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

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

2.7.6.2.10.2 The CONTRACTOR shall contact a minimum of twenty-five (25) state agencies or community-based organizations per quarter, to either educate them on services available through the CONTRACTOR or to develop outreach and educational initiatives. All of the agencies engaged shall be those who serve TennCare enrollees. Collaborative activities should include those designed to reach enrollees with limited English proficiency, low literacy levels, behavioral health and special health care needs or who are pregnant.

2.7.6.3 Screening

2.7.6.3.1 The CONTRACTOR shall provide periodic comprehensive child health assessments meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth."

2.7.6.3.2 At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare web site. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.

2.7.6.3.3 The screens shall include, but not be limited to:

2.7.6.3.3.1 Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);

2.7.6.3.3.2 Comprehensive unclothed physical examination, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender);

2.7.6.3.3.3 Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;

2.7.6.3.3.4 Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;

2.7.6.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than ten (10) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and

2.7.6.3.3.6 Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members' parents or to the legally appointed representative to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

2.7.6.3.4 The CONTRACTOR shall encourage providers to refer children to dentists for periodic dental screens beginning no later than three (3) years of age and earlier as needed (as early as six (6) to twelve (12) months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate.

2.7.6.3.5 The CONTRACTOR shall establish a procedure for PCPs or other providers completing TENNderCare screenings to refer TENNderCare eligible members requiring behavioral health services to appropriate providers.

2.7.6.4 <u>Services</u>

2.7.6.4.1 Should screenings indicate a need, the CONTRACTOR shall provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section 2.7.6.4.8). This includes, but is not limited to, the services detailed below.

2.7.6.4.2 The CONTRACTOR shall provide treatment for defects in vision and hearing, including eyeglasses and hearing aids.

2.7.6.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TENNderCare eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.

2.7.6.4.4 The CONTRACTOR shall not require prior authorization or written PCP referral in order for a member to obtain a mental health or substance abuse assessment, whether

the assessment is requested as follow-up to a TENNderCare screening or an interperiodic screening. This requirement shall not preclude the CONTRACTOR from requiring notification for a referral for an assessment. Furthermore, the CONTRACTOR shall establish a procedure for PCPs, or other providers, completing TENNderCare screenings, to refer members under the age of twenty-one (21) for a mental health or substance abuse assessment.

2.7.6.4.5 For services not covered by Section 1905(a) of the Social Security Act, but found to be needed as a result of conditions disclosed during screening and diagnosis, the CONTRACTOR shall provide referral assistance as required by 42 CFR 441.61, including referral to providers and State health agencies.

2.7.6.4.6 *Transportation Services*

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

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

2.7.6.4.7 *Services for Elevated Blood Lead Levels*

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

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

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

2.7.6.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is

not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

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

2.7.6.4.8 *Services Chart*

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

Services Listed in Social Security Act Section 1905(a)		**Responsible Entity in Tennessee**	**Comments**
(1) Inpatient hospital services (other than services in an institution for mental diseases)		MCO	
(2)(A) Outpatient hospital services		MCO	
(2)(B) Rural health clinic services (RHCs)		MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)		MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services		MCO	
(4)(A) Nursing facility services for individuals age 21 and older			Not applicable for TENNderCare

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(4)(B) EPSDT services		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services as described except as in Section 2.6.1.3	
(4)(C) Family planning services and supplies		MCO; PBM for pharmacy services except as described in Section 2.6.1.3	
(5)(A) Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility		MCO	
(5)(B) Medical and surgical services furnished by a dentist		DBM except as described in Section 2.6.1.3	
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law		MCO	See Item (13)
(7) Home health care services		MCO	
(8) Private duty nursing services		MCO	
(9) Clinic services		MCO	
(10) Dental services		DBM except as described in Section 2.6.1.3	
(11) Physical therapy and related services		MCO	
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses		MCO; PBM for pharmacy services except as described in Section 2.6.1.3; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative		MCO for physical health and behavioral health services; DBM for dental services	The following are considered practitioners of the healing arts in

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level		except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	Tennessee law:[1] • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional

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

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			• X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases			Not applicable for TENNderCare
(15) Services in an intermediate care facility for the mentally retarded		TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21		MCO	
(17) Services furnished by a nurse-midwife		MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care		MCO	
(19) Case management services		MCO	
(20) Respiratory care services		MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner		MCO	The MCOs are not required to contract with PNPs or CFNPs if the services are available through other contract providers.
(22) Home and community care for functionally disabled elderly individuals			Not applicable for TENNderCare
(23) Community supported living arrangements services			Not applicable for TENNderCare
(24) Personal care services		MCO	

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(25) Primary care case management services			Not applicable
(26) Services furnished under a PACE program			Not applicable for TENNderCare
(27) Any other medical care, and any other type of remedial care recognized under state law.		MCO for physical and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	See Item (13)

2.7.6.4.8.1 **Note 1:** "Targeted case management services," which are listed under Section 1915(g)(1), are **not TENNderCare services** except to the extent that the definition in Section 1915(g)(2) is used with Item (19) above.

2.7.6.4.8.2 **Note 2:** "Psychiatric residential treatment facility" is not listed in Social Security Act Section 1905(a). It is, however, defined in 42 CFR 483.352 as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age twenty-one (21), in an inpatient setting."

2.7.6.4.8.3 **Note 3:** "Rehabilitative" services are differentiated from "habilitative" services in federal law. "Rehabilitative" services, which are TENNderCare services, are defined in 42 CFR 440.130(d) as services designed "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." "Habilitative" services, which are **not TENNderCare services**, are defined in Section 1915(c)(5) as services designed "to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

2.7.6.4.8.4 **Note 4:** Certain services are covered under a Home and Community Based waiver but are **not TENNderCare services** because they are not listed in the Social Security Act Section 1905(a). These services include habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)

2.7.6.4.8.5 **Note 5:** Certain services are not coverable even under a Home and Community Based waiver and are **not TENNderCare services**. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

2.7.6.5 Children with Special Health Care Needs

Children with special health care needs are those children who are in the custody of DCS. As provided in Section 2.4.4.4, TennCare enrollees who are in the custody of DCS will be enrolled in TennCare Select.

2.7.7 **Advance Directives**

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

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

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

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

2.7.7.5 For CHOICES members, the care coordinator shall educate members about their ability to use advance directives during the face-to-face intake visit for current members or the face-to-face visit with new members, as applicable.

2.7.8 **Sterilizations, Hysterectomies and Abortions**

2.7.8.1 The CONTRACTOR shall cover sterilizations, hysterectomies and abortions 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.

2.7.8.2 Sterilizations

Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing. The CONTRACTOR shall cover sterilizations only if the following requirements are met:

2.7.8.2.1 At least thirty (30) calendar days, but not more than one hundred eighty (180) calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least seventy-two (72) hours have passed since the member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least thirty (30) calendar days before the expected date of delivery;

2.7.8.2.2 The member is at least twenty-one (21) years old at the time consent is obtained;

2.7.8.2.3 The member is mentally competent;

2.7.8.2.4 The member is not institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed); and

2.7.8.2.5 The member has voluntarily given informed consent on the approved "STERILIZATION CONSENT FORM" which is available on TENNCARE's web site. The form shall be available in English and Spanish, and the CONTRACTOR shall provide assistance in completing the form when an alternative form of communication is necessary.

2.7.8.3 Hysterectomies

2.7.8.3.1 Hysterectomy shall mean a medical procedure or operation for the purpose of removing the uterus. The CONTRACTOR shall cover hysterectomies only if the following requirements are met:

2.7.8.3.1.1 The hysterectomy is medically necessary;

2.7.8.3.1.2 The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing; and

2.7.8.3.1.3 The member or her authorized representative, if any, has signed and dated an "ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION" form which is available on the Bureau of TennCare's web site, prior to the hysterectomy. Informed consent shall be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance shall be provided in completing the form when an alternative form of communication is necessary. Refer to "ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION" form and instructions for additional guidance and exceptions.

2.7.8.3.2 The CONTRACTOR shall not cover hysterectomies under the following circumstances:

2.7.8.3.2.1 If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing;

2.7.8.3.2.2 If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing; or

2.7.8.3.2.3 It is performed for the purpose of cancer prophylaxis.

2.7.8.4 Abortions

2.7.8.4.1 The CONTRACTOR shall cover abortions and services associated with the abortion procedure only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

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

10. Section 2.8 shall be deleted in its entirety and replaced with the following:

2.8 DISEASE MANAGEMENT

2.8.1 **General**

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

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

2.8.1.1.2 Diabetes;

2.8.1.1.3 Congestive heart failure;

2.8.1.1.4 Asthma;

2.8.1.1.5 Coronary artery disease;

2.8.1.1.6 Chronic-obstructive pulmonary disease;

2.8.1.1.7 Bipolar disorder;

2.8.1.1.8 Major depression; and

2.8.1.1.9 Schizophrenia.

2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care. For the conditions listed in 2.8.1.1.1 through 2.8.1.1.9, the guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.

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

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

2.8.1.4.1 The definition of the target population;

2.8.1.4.2 Member identification strategies, which shall not exclude CHOICES members, including dual eligible CHOICES members;

2.8.1.4.3 The guidelines;

2.8.1.4.4 Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;

2.8.1.4.5 Program content;

2.8.1.4.6 Targeted methods for informing and educating members which may include, but shall not be limited to mailing educational materials;

2.8.1.4.7 Methods for informing and educating providers; and

2.8.1.4.8 Program evaluation.

2.8.1.5 As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

2.8.1.6 The CONTRACTOR's DM and care coordination policies and procedures shall address how the CONTRACTOR shall ensure that upon enrollment into CHOICES, disease management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health,

behavioral health, and long-term care services, including appropriate management of conditions specified in 2.8.1.1. If a CHOICES member has one or more of the conditions specified in Section 2.8.1.1, the member's care coordinator may use the CONTRACTOR's applicable DM tools and resources, including staff with specialized training, to help manage the member's condition and shall integrate the use of these DM tools and resources with care coordination. DM staff shall supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR's policies and procedures shall also include at a minimum how the CONTRACTOR will address the following for CHOICES members:

2.8.1.6.1 Notify the member's care coordinator of the member's participation in a DM program;

2.8.1.6.2 Provide to the member's care coordinator information about the member collected through the DM program;

2.8.1.6.3 Provide to the care coordinator any educational materials given to the member through the DM program;

2.8.1.6.4 Ensure that the care coordinator reviews the information noted in Section 2.8.1.6.3 above verbally with the member and with the member's paid and/or unpaid caregiver and coordinates any necessary follow-up that may be needed regarding the DM program such as scheduling screenings or appointments;

2.8.1.6.5 Ensure that the care coordinator integrates into the member's plan of care aspects of the DM program that would help to better manage the member's condition; and

2.8.1.6.6 Ensure that the member's care coordinator shall be responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which shall be integrated into the member's plan of care and which shall include monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which will help to better ensure management of the member's condition (see Section 2.9.6 of this Agreement).

2.8.1.7 The CONTRACTOR shall implement DM programs specific to CHOICES members in accordance with the following schedule:

2.8.1.7.1 After the second calendar quarter following CHOICES implementation in the Grand Region covered by this Agreement, the CONTRACTOR shall implement DM programs for CHOICES members for four of the six disease management conditions listed in Sections 2.8.1.1.2, 2.8.1.1.3, 2.8.1.1.5, 2.8.1.1.6, 2.8.1.1.8, and 2.8.8).

2.8.1.7.2 After the fourth calendar quarter following CHOICES implementation in the Grand Region covered by this Agreement, the CONTRACTOR shall implement DM programs for CHOICES members for the two DM conditions listed in Sections 2.8.1.1.2, 2.8.1.1.3, 2.8.1.1.5, 2.8.1.1.6, 2.8.1.1.8, and 2.8.8 for which the CONTRACTOR has not developed a DM program for CHOICES members.

2.8.1.7.3 After the sixth calendar quarter following CHOICES implementation in the Grand Region covered by this Agreement, the CONTRACTOR shall implement DM programs for CHOICES members for the three DM conditions listed in Sections 2.8.1.1.4, 2.8.1.1.7, and 2.8.1.1.9, for a total of nine (9) DM programs for CHOICES members.

2.8.2 **Member Identification Strategies**

2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program, including CHOICES members, through the same processes used for identification of non-CHOICES members and the CHOICES care coordination process..

2.8.2.2 The CONTRACTOR shall operate its disease management programs using an "opt out" methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.3 **Stratification**

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information 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.

2.8.4 **Program Content**

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

2.8.5 **Informing and Educating Members**

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

2.8.5.1 Are proactive and effective partners in their care;

2.8.5.2 Understand the appropriate use of resources needed for their care;

2.8.5.3 Identify precipitating factors and appropriate responses before they require more acute intervention; and

2.8.5.4 Are compliant and cooperative with the recommended treatment plan.

2.8.6 **Informing and Educating Providers**

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

2.8.7 **Program Evaluation (Satisfaction and Effectiveness)**

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

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

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

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

2.8.7.2.2 The rate of emergency department utilization, inpatient hospitalization, and nursing facility admission;

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

2.8.7.2.4 Appropriate HEDIS measures;

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

2.8.7.2.6 Cost savings;

2.8.7.2.7 Member adherence to treatment plans; and

2.8.7.2.8 Provider adherence to the guidelines.

2.8.7.3 For CHOICES members, measures of member satisfaction and effectiveness shall be reported by the type of setting in which long-term care services are delivered in order to facilitate comparison across long-term care service delivery settings.

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

2.8.8 **Obesity Disease Management**

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.5). The CONTRACTOR may fulfill this requirement by entering into a provider agreement with Weight Watchers and then referring/authorizing eligible obese and overweight members to participate in a Weight Watchers program. If the CONTRACTOR identifies another weight management program as the cost effective alternative service, the CONTRACTOR shall include a narrative of the program (including target population and description of services) as part of its quarterly disease management report (see Section 2.30.5.1) applicable to the quarter in which the program was implemented.

11. Section 2.9 shall be deleted in its entirety and replaced with the following:

2.9 SERVICE COORDINATION

2.9.1 **General**

2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility. For CHOICES members, these policies and procedures shall specify the role of the care coordinator/care coordination team in conducting these functions (see Section 2.9.6).

2.9.1.2 The CONTRACTOR shall:

2.9.1.2.1 Coordinate care among PCPs, specialists, behavioral health providers, and long-term care providers;

2.9.1.2.2 Perform reasonable preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;

2.9.1.2.3 Monitor members with ongoing medical or behavioral health conditions;

2.9.1.2.4 Provide care coordination to CHOICES members (see Section 2.9.6);

2.9.1.2.5 Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home;

2.9.1.2.6 Maintain and operate a formalized hospital and/or institutional discharge planning program;

2.9.1.2.7 Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;

2.9.1.2.8 Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member; and

2.9.1.2.9 Authorize services provided by non-contract providers, as required in this Agreement (see, e.g., Section 2.13).

2.9.2 **Transition of New Members**

2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. Except as specified in this Section 2.9.2 or in Sections 2.9.3 or 2.9.6, this requirement shall not apply to long-term care services.

2.9.2.1.1 For medically necessary covered services, other than long-term care services, being provided by a non-contract provider, the CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption to a contract provider, whichever is less. The CONTRACTOR may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.9.2.1.2 For medically necessary covered services, other than long-term care services, being provided by a contract provider, the CONTRACTOR shall provide continuation of such services from that provider but may require prior authorization for continuation of such services from that provider beyond thirty (30) calendar days. The CONTRACTOR may initiate a provider change only as otherwise specified in this Agreement.

2.9.2.1.3 For medically necessary covered long-term care services for CHOICES members who are new to both TennCare and CHOICES, the CONTRACTOR shall provide long-term care services as specified in Sections 2.9.6.2.4 and 2.9.6.2.5.

2.9.2.1.4 For covered long-term care services for CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both HCBS authorized by the transferring MCO and nursing facility services, without regard to whether such services are being provided by contract or non-contract providers.

2.9.2.1.4.1 For a member in CHOICES Group 2 or 3, the CONTRACTOR shall continue HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce these services unless a care coordinator has conducted a comprehensive needs assessment and

developed a plan of care, and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 or 3 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

2.9.2.1.4.2 For a member in CHOICES Group 2 or 3, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If a member in Group 2 or 3 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.

2.9.2.1.4.3 If at any time before conducting a comprehensive needs assessment for a member in CHOICES Group 2 or 3 the CONTRACTOR becomes aware of an increase in the member's needs, a care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs.

2.9.2.1.4.4 For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, a care coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5). For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for ninety (90) days or more, a care coordinator shall conduct a face-to-face in-facility visit within sixty (60) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5).

2.9.2.1.4.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.

2.9.2.1.4.6 The CONTRACTOR shall not:

2.9.2.1.4.6.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

2.9.2.1.4.6.2 Transition Group 1 members to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1;

2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1; or

2.9.2.1.4.6.5 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall

provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

2.9.2.1.5 For CHOICES members who are transferring to the CONTRACTOR's MCO serving the Grand Region covered by this Agreement from a Grand Region where CHOICES has not yet been implemented, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both HCBS in the member's approved HCBS E/D waiver plan of care and nursing facility services.

2.9.2.1.5.1 For CHOICES members in Group 2, the CONTRACTOR shall be responsible for continuing to provide HCBS in accordance with the member's approved HCBS E/D waiver plan of care for a minimum of thirty (30) calendar days after enrollment; thereafter the CONTRACTOR shall not reduce the member's HCBS unless a care coordinator has conducted a comprehensive needs assessment and developed a plan of care, and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

2.9.2.1.5.2 For a member in CHOICES Group 2, within thirty (30) days of notice of the member's enrollment, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If the member is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, and within no more than thirty (30) days of the member's enrollment, to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged for the nursing facility and remain in Group 2 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.

2.9.2.1.5.3 If at any time before conducting the comprehensive needs assessment for a member in CHOICES Group 2 the CONTRACTOR becomes aware of an increase in the member's needs, a care coordinator shall immediately conduct a

comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the change in the member's needs.

2.9.2.1.5.4 For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, a care coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5). For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for ninety (90) days or more, a care coordinator shall conduct a face-to-face in-facility visit within sixty (60) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5).

2.9.2.1.5.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.

2.9.2.1.5.6 The CONTRACTOR shall not:

2.9.2.1.5.6.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (c) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

2.9.2.1.5.6.2 Transition Group 1 members to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.2.1.5.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1; or

2.9.2.1.5.6.4 Transition members in Group 2 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider.

2.9.2.2.1 If the member is receiving services from a non-contract provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

2.9.2.2.2 If the member is receiving services from a contract provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.

2.9.2.3 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period, without any form of prior approval.

2.9.2.4 If a member enrolls in the CONTRACTOR's MCO from another MCO, the CONTRACTOR shall immediately contact the member's previous MCO and request the transfer of "transition of care data" as specified by TENNCARE. If the CONTRACTOR is contacted by another MCO requesting "transition of care data" for a member who has transferred from the CONTRACTOR to the requesting MCO (as verified by the CONTRACTOR), the CONTRACTOR shall provide such data in the timeframe and format specified by TENNCARE.

2.9.2.5 If the CONTRACTOR becomes aware that a CHOICES member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the member's care coordinator) shall work with the other MCO in facilitating a seamless transition for that member. If a member in Group 2 or 3 is transferring to a Grand Region where CHOICES has not been implemented, the care coordinator shall provide the local Area Agency on Aging and Disability (AAAD) with the member's plan of care and other information specified by TENNCARE within the timeframe and in the format specified by TENNCARE and shall work with the AAAD to facilitate a seamless transition for that member.

2.9.2.6 The CONTRACTOR shall ensure that any member entering the CONTRACTOR's MCO is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing and patient liability amounts (see Section 2.6.7 of this Agreement).

2.9.2.7 The CONTRACTOR shall develop and maintain policies and procedures regarding the transition of new members.

2.9.3 **Transition of Members Receiving Long-Term Care Services at the Time of CHOICES Implementation**

2.9.3.1 For each member who is enrolling in CHOICES as of the date of CHOICES implementation in the Grand Region covered by this Agreement, as identified by TENNCARE (herein referred to as "transitioning CHOICES members"), the CONTRACTOR shall assign a care coordinator prior to the first face-to-face visit. If the face-to-face visit will not occur within ten (10) days after the implementation of CHOICES, the CONTRACTOR shall send the member written notification within ten (10) calendar days of implementation that explains how the member can reach the care coordination unit for assistance with concerns or questions pending the assignment of a specific care coordinator.

2.9.3.2 For each transitioning CHOICES member, the CONTRACTOR shall be responsible for the costs of continuing to provide covered long-term care services previously authorized by TENNCARE or its designee, including, as applicable, HCBS in the member's approved HCBS E/D waiver plan of care and nursing facility services without regard to whether such services are being provided by contract or non-contract providers.

2.9.3.3 For members in Group 2 the CONTRACTOR shall continue HCBS in the member's approved HCBS E/D waiver plan of care except case management for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce HCBS unless the member's care coordinator has conducted a comprehensive needs assessment and developed a plan of care and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12).

2.9.3.4 For a member in CHOICES Group 2, within ninety (90) days of CHOICES implementation, the member's care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate HCBS in accordance with the new plan of care. If a member in Group 2 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR the member's care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing services approved by TENNCARE, but no more than ninety (90) days after CHOICES implementation, to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to ninety (90) days after CHOICES implementation, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.

2.9.3.5 If at any time before conducting a comprehensive needs assessment for a member in CHOICES Group 2 the CONTRACTOR becomes aware of an increase in the member's needs, the member's care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the change in the member's needs.

2.9.3.6 The CONTRACTOR shall provide nursing facility services to a member in Group 1 in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

2.9.3.7 For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, the member's care coordinator shall conduct a face-to-face in-facility visit within ninety (90) days of the implementation of CHOICES and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5.1). For a member in CHOICES Group 1 who, at the time of implementation of CHOICES, has resided in a nursing facility for ninety (90) days or more, the member's care coordinator shall conduct a face-to-face in-facility visit within six (6) months of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5.1).

2.9.3.8 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.

2.9.3.9 The CONTRACTOR shall not:

2.9.3.9.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file,

(2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

2.9.3.9.2 Transition Group 1 members to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.3.9.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1; or

2.9.3.9.4 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

2.9.4 Transition of Care

2.9.4.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving long-term care services, and members who are pregnant in transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, currently providing their long-term care services, or currently providing prenatal services has terminated participation with the CONTRACTOR. For CHOICES members, this assistance shall be provided by the member's care coordinator/care coordination team.

2.9.4.1.1 Except as provided below regarding members who are in their second or third trimester of pregnancy, the CONTRACTOR shall provide continuation of such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.

2.9.4.1.2 For members in their second or third trimester of pregnancy, the CONTRACTOR shall allow continued access to the member's prenatal care provider and any provider currently treating the member's chronic or acute medical or behavioral health condition or currently providing long-term care services, through the postpartum period.

2.9.4.2 The CONTRACTOR shall actively assist members in transitioning to another provider when there are changes in providers. The CONTRACTOR shall have transition policies that, at a minimum, include the following:

2.9.4.2.1 A schedule which ensures transfer does not create a lapse in service;

2.9.4.2.2 For CHOICES members in Groups 2 and 3, the requirement for a HCBS provider that is no longer willing or able to provide services to a member to cooperate with the member's care coordinator to facilitate a seamless transition to another HCBS provider (see Section 2.12.12.1) and to continue to provide services to the member until the member has been transitioned to another HCBS provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR (see Section 2.12.12.2);

2.9.4.2.3 A mechanism for timely information exchange (including transfer of the member record);

2.9.4.2.4 A mechanism for assuring confidentiality;

2.9.4.2.5 A mechanism for allowing a member to request and be granted a change of provider;

2.9.4.2.6 An appropriate schedule for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.

2.9.4.2.7 Specific transition language on the following special populations:

2.9.4.2.7.1 Children who are SED;

2.9.4.2.7.2 Adults who are SPMI;

2.9.4.2.7.3 Persons who have addictive disorders;

2.9.4.2.7.4 Persons who have co-occurring disorders of both mental health and substance abuse disorders; and

2.9.4.2.7.5 Persons with behavioral health conditions who also have a developmental disorder (dually diagnosed). These members shall be allowed to remain with their providers of the services listed below for the minimum time frames set out below as long as the services continue to be medically necessary. The CONTRACTOR may shorten these transition time frames only when the provider of services is no

longer available to serve the member or when a change in providers is agreed to in writing by the member.

2.9.4.2.7.5.1 Mental health case management: three (3) months;

2.9.4.2.7.5.2 Psychiatrist: three (3) months;

2.9.4.2.7.5.3 Outpatient behavioral health therapy: three (3) months;

2.9.4.2.7.5.4 Psychosocial rehabilitation and supported employment: three (3) months; and

2.9.4.2.7.5.5 Psychiatric inpatient or residential treatment and supported housing: six (6) months.

2.9.5 **MCO Case Management**

2.9.5.1 The CONTRACTOR shall maintain an MCO case management program that includes the following components:

2.9.5.1.1 A systematic approach to identify eligible members;

2.9.5.1.2 Assessment of member needs;

2.9.5.1.3 Development of an individualized plan of care;

2.9.5.1.4 Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and

2.9.5.1.5 Program Evaluation (Satisfaction and Effectiveness).

2.9.5.2 The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.

2.9.5.3 The CONTRACTOR has the option of allowing members to be enrolled in both MCO case management and a disease management program.

2.9.5.4 The CONTRACTOR shall ensure that, upon a member's enrollment in CHOICES, MCO case management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's MCO case management program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team.

2.9.5.5 Eligible members shall be offered MCO case management services. However, member participation shall be voluntary.

2.9.5.6 The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP and/or appropriate specialist when a member has been assigned to the MCO case management program.

2.9.5.7 The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM (see Section 2.9.10), to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has exceeded the ED threshold (see Section 2.14.1.13).

2.9.6 **Care Coordination**

2.9.6.1 General

2.9.6.1.1 The CONTRACTOR shall provide care coordination to all persons enrolled in TennCare CHOICES in accordance with this Agreement and to other TennCare members only in order to determine the member's eligibility for and facilitate the member's enrollment in TennCare CHOICES. Except for the initial process for current members that is necessary to determine the member's eligibility for and facilitate the member's enrollment in TennCare CHOICES, care coordination shall not be available to non-CHOICES members.

2.9.6.1.2 The CONTRACTOR shall provide care coordination in a comprehensive, holistic, person-centered manner.

2.9.6.1.3 The CONTRACTOR shall use care coordination as the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

2.9.6.1.4 Long-term care services identified through care coordination and provided by the CONTRACTOR shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.

2.9.6.1.5 The CONTRACTOR shall develop and implement policies and procedures for care coordination that comply with the requirements of this Agreement.

2.9.6.1.6 The CONTRACTOR's failure to meet requirements, including timelines, for care coordination set forth in this Agreement, except for good cause, constitutes non-compliance with this Agreement. Such failure shall not affect any determination of eligibility for CHOICES enrollment, which shall be based only on whether the member meets CHOICES eligibility and enrollment criteria, as defined pursuant to the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols. Nor shall such failure affect any determination of coverage for CHOICES benefits which shall be based only on the covered benefits for the applicable CHOICES group in which the member is enrolled as defined pursuant to the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols; and in accordance with requirements pertaining to medical necessity.

2.9.6.1.7 The CONTRACTOR shall ensure that its care coordination program complies with 42 CFR 438.208.

2.9.6.1.8 The CONTRACTOR shall ensure that, upon enrollment into CHOICES, MCO case management and/or disease management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs, including appropriate management of conditions specified in 2.8.1.1. The care coordinator may use resources and staff from the CONTRACTOR's case management and disease management programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the care coordinator/care coordination team.

2.9.6.2 Intake Process for Members New to Both TennCare and CHOICES

2.9.6.2.1 The CONTRACTOR shall refer all inquiries regarding CHOICES enrollment by or on behalf of individuals who are not enrolled with the CONTRACTOR to TENNCARE or its designee. The form and format for such referrals shall be developed in collaboration with the CONTRACTOR and TENNCARE or its designee.

2.9.6.2.2 TENNCARE or its designee will assist individuals who are not enrolled in TennCare with TennCare eligibility and CHOICES enrollment.

2.9.6.2.3 *Functions of the Single Point of Entry (SPOE)*

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tool and protocols specified by TENNCARE, to assist with intake for persons new to both TennCare and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet nursing facility level of care; and (3) for applicants seeking access to HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.

2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the applicant upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system.

2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (4) provide information regarding freedom of choice of nursing facility versus HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed by the applicant or his/her representative; (5) for applicants who want to receive NF services (a) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility provider, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (b) provide information regarding the completion of all PASRR requirements prior to nursing facility admission; (6) for applicants who are seeking HCBS: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the applicant regarding the individual cost neutrality cap, and notification to and signed acknowledgement of understanding by the applicant or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (7) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The listing of HCBS and home health and/or private duty nursing services the member may need shall be used by TENNCARE or its designee to determine whether services can be provided within the member's cost neutrality cap and may be further refined based on the CONTRACTOR's comprehensive needs assessment and plan of care development processes.

2.9.6.2.3.6 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.2.3.7 TENNCARE will notify the CONTRACTOR via the 834 eligibility file when a person has been enrolled in CHOICES and the member's CHOICES Group. For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and see Section 2.6.1.5.2.3). For members in CHOICES Group 1, TENNCARE will notify the CONTRACTOR of applicable patient liability amounts (see Section 2.6.7.2).

2.9.6.2.3.8 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and signed risk agreement (for members in CHOICES Group 2), and the services identified by TENNCARE or its designee.

2.9.6.2.4 *Functions of the CONTRACTOR for Members in CHOICES Group 1*

2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall immediately authorize such services in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12). Authorization for such services shall be from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

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 CHOICES and have received such services for ninety (90) days or more, the CONTRACTOR shall, within sixty (60) 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).

2.9.6.2.4.3 The care coordinator shall, for members in CHOICES Group 1 who are receiving services in a nursing facility at the time of enrollment in CHOICES and are new admissions to a nursing facility, having resided in the nursing facility for less than ninety (90) days, 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 in Section 2.9.6.6.1).

2.9.6.2.4.4 For members in CHOICES Group 1 who are waiting for placement in a nursing facility, within ten (10) calendar days of notice of the member's enrollment in CHOICES (1) the member's care coordinator shall conduct a face-to-face visit with the member, which shall include (a) member education regarding choice of contract nursing facility providers, subject to the provider's availability and willingness to timely delivery services, and obtain signed confirmation of the member's choice of nursing facility; and (b) performing any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1); and (2) the CONTRACTOR shall authorize and initiate nursing facility services. Upon admission to a nursing facility, the care coordinator shall participate as appropriate in the nursing facility's care planning process (see Section 2.9.6.6.1.2) and may supplement the plan of care as necessary (see Section 2.9.6.6.1.1).

2.9.6.2.4.5 The CONTRACTOR shall not divert or transition members in Group 1 to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility and is enrolled in Group 2 or 3.

2.9.6.2.4.6 The CONTRACTOR shall ensure that all PASRR requirements are met prior to a member's admission to a nursing facility.

2.9.6.2.4.7 For purposes of the CHOICES program, service authorization for nursing facility services shall be for the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12) and shall include the duration of nursing facilities services to be provided; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR shall be responsible for confirming the nursing facility's capacity and commitment to initiate services as authorized on or before the requested start date, and if the nursing facility is unable to initiate services as authorized on or before the requested start date, for arranging an alternative nursing facility that is able to initiate services as authorized on or before the requested start date in accordance with Section 2.9.6.2.4.8.

2.9.6.2.4.8 If the CONTRACTOR is unable to place a member in the nursing facility requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested nursing facility and the available options and identify an alternative nursing facility.

2.9.6.2.4.9 If the CONTRACTOR is unable to initiate any nursing facility service(s) in accordance with the timeframes specified in Section 2.9.6.2.4.1, the CONTRACTOR shall issue written notice to the member, documenting that the service will be delayed, the reasons for the delay, and the date the service will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.2.4.10 For CHOICES members approved by TENNCARE for Level II (or skilled) nursing facility services, the CONTRACTOR shall be responsible for monitoring the member's continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when Level II nursing facility services are no longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care for nursing facility services (see also Section 2.14.1.12.2).

2.9.6.2.5 *Functions of the CONTRACTOR for Members in CHOICES Groups 2 and 3*

2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services, the CONTRACTOR shall, immediately upon notice of the member's enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. In the case of those members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility, community-based residential alternative services shall be authorized immediately upon notice of the member's categorical and financial eligibility for TennCare CHOICES as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider

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) calendar 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) calendar 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 five (5) days of notice.

2.9.6.2.5.4 At the discretion of the CONTRACTOR, authorization of home health or private duty nursing services may be completed by the care coordinator or through the CONTRACTOR's established UM processes but shall be in accordance with Section 2.9.2.1 of this Agreement, which requires the CONTRACTOR to continue providing medically necessary home health or private duty nursing services the member was receiving upon TennCare enrollment.

2.9.6.2.5.5 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless: (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.2.5.6 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1.

2.9.6.2.5.7 In preparation for the face-to-face visit, the care coordinator shall review in-depth the information from the SPOE's intake process (see Section 2.9.6.2.3), and the care coordinator shall consider that information, including the services identified by TENNCARE or its designee, when developing the member's plan of care.

2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the care coordinator shall review, and revise as necessary, the member's risk assessment and risk agreement and have the member or his/her representative sign any revised risk agreement.

2.9.6.2.5.9 As part of the face-to-face visit, the care coordinator shall provide member education regarding choice of contract providers for HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.

2.9.6.2.5.10 For purposes of the CHOICES program, service authorizations shall include the amount, frequency, and duration of each service to be provided and the schedule at which such care is needed, as applicable; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR shall be responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, for arranging an alternative provider who is able to initiate services as authorized on or before the requested start date.

2.9.6.2.5.11 The member's care coordinator/care coordination team shall provide at least verbal notification to the member prior to initiation of HCBS identified in the plan of care regarding any change in providers selected by the member for each HCBS, including the reason such change has been made.

2.9.6.2.5.12 If the CONTRACTOR is unable to initiate any HCBS in accordance with the timeframes specified herein, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.2.5.13 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities when there is a waiting list, which may include at the time of CHOICES implementation.

2.9.6.3 <u>CHOICES Intake Process for the CONTRACTOR's Current Members</u>

2.9.6.3.1 The CONTRACTOR shall develop and implement policies and procedures for ongoing identification of members who may be eligible for CHOICES. The CONTRACTOR shall use the following, at a minimum, to identify members who may be eligible for CHOICES:

2.9.6.3.1.1 Referral from member's PCP, specialist or other provider or other referral source;

2.9.6.3.1.2 Self-referral by member or referral by member's family or guardian;

2.9.6.3.1.3 Referral from CONTRACTOR's staff including but not limited to DM, MCO case management, and UM staff;

2.9.6.3.1.4 Notification of hospital admission (see Section 2.12.9.38); and

2.9.6.3.1.5 Upon notice from TENNCARE but no more than one hundred eighty (180) days following implementation of CHOICES in the Grand Region covered by this Agreement, periodic review (at least quarterly) of:

2.9.6.3.1.5.1 Claims or encounter data;

2.9.6.3.1.5.2 Hospital admission or discharge data;

2.9.6.3.1.5.3 Pharmacy data; and

2.9.6.3.1.5.4 Data collected through the DM and/or UM processes.

2.9.6.3.1.5.5 The CONTRACTOR may define in its policies and procedures, other steps that will be taken to better assess if the members identified through means other than referral or notice of hospital admission will likely qualify for CHOICES, and may target its screening and intake efforts to a more targeted list of persons that are most likely to need and to qualify for CHOICES services.

2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member's current eligibility category based on information provided by TENNCARE in the 834 eligibility file; for persons seeking access to HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility category, and if not, for persons seeking to enroll in CHOICES Group 2, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS) category); (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

2.9.6.3.3 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, if the CONTRACTOR opts to use a telephone screening process, the CONTRACTOR shall make every effort to conduct such screening process at the time of referral, unless the person making the referral is not able or not authorized by the member to assist with the screening process, in which case the CONTRACTOR shall complete the telephone screening process as expeditiously as possible.

2.9.6.3.3.1 Documentation of at least three (3) attempts to contact the member by phone (which shall include at least one (1) attempt to contact the member at the number most recently reported by the member and at least one (1) attempt to contact the member at the number provided in the referral, if different), followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES, shall constitute sufficient effort by the CONTRACTOR to assist a member who has been referred for CHOICES, regardless of referral source.

2.9.6.3.4 For persons identified through notification of hospital admission, the CONTRACTOR shall work with the discharge planner to determine whether long-

term care services may be needed upon discharge, and if so, shall complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.

2.9.6.3.5 For identification by the CONTRACTOR of a member who may be eligible for CHOICES by means other than referral or notice of hospital admission, if the CONTRACTOR opts to use a telephone screening process, the CONTRACTOR shall complete the telephone screening process as expeditiously as possible.

2.9.6.3.5.1 Documentation of at least one (1) attempt to contact the member by phone at the number most recently reported by the member, followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES shall constitute sufficient effort by the CONTRACTOR to assist a member that has been identified by the CONTRACTOR by means other than referral.

2.9.6.3.6 If the CONTRACTOR uses a telephone screening process, the CONTRACTOR shall document all screenings conducted by telephone and their disposition, with a written record.

2.9.6.3.7 If the member does not meet the telephone screening criteria, the CONTRACTOR shall notify the member verbally and in writing: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall conduct a face-to-face intake visit, including level of care assessment and needs assessment, within five (5) business days of receipt of the member's written request.

2.9.6.3.8 If, through the screening process described above, or upon other identification by the CONTRACTOR of a member who appears to be eligible for CHOICES for whom the CONTRACTOR opts not to use such screening process, the care coordinator shall conduct a face-to-face intake visit with the member that includes a level of care assessment and a needs assessment (see Section 2.9.6.5) using tool(s) prior approved by TENNCARE and in accordance with the protocols specified by TENNCARE. The CONTRACTOR shall complete the telephone screening process and the face-to-face intake visit with the member within six (6) business days of receipt of the referral.

2.9.6.3.8.1 For members in a nursing facility or seeking nursing facility services, the care coordinator shall perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1).

2.9.6.3.8.2 For members seeking HCBS, the care coordinator shall, using the tools and protocols specified by TENNCARE, assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or

private funding sources, such as Medicare or long-term care insurance; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the member upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system.

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator/care coordination team shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in facilitating gathering of categorical/financial documentation needed by DHS; (4) provide information regarding freedom of choice of nursing facility versus HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed by the member or his/her representative; (5) for members who want to receive nursing facility services, (a) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility provider, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (b) provide information regarding the completion of all PASRR requirements prior to nursing facility admission; (6) for members who are seeking HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the member regarding the individual cost neutrality cap, and notification to and signed acknowledgement of understanding by the member or his/her representative that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; and (7) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

2.9.6.3.10 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within six (6) business days of receipt of such referral, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

2.9.6.3.11 For members identified by the CONTRACTOR as potentially eligible for CHOICES by means other than referral, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6),

within thirty (30) days of identification of the member as potentially eligible for CHOICES. For persons identified through notification of hospital admission, the CONTRACTOR shall coordinate with the hospital discharge planner to determine whether long-term care services may be needed upon discharge, and if so, complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.

2.9.6.3.12 Once completed, the CONTRACTOR shall submit the level of care and, for members requesting HCBS, documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap to TENNCARE within one (1) business day.

2.9.6.3.13 If the member is seeking access to HCBS through enrollment in CHOICES Group 2 and the enrollment target for CHOICES Group 2 has been reached, the CONTRACTOR shall notify TENNCARE, at the time of submission of the level of care and needs assessment and plan of care, as appropriate, whether the person shall be placed on a waiting list for CHOICES Group 2. If the CONTRACTOR wishes to enroll the person in CHOICES Group 2 as a cost effective alternative (CEA) to nursing facility care that would otherwise be provided, the CONTRACTOR shall submit to TENNCARE the following:

2.9.6.3.13.1 A written summary of the CONTRACTOR's CEA determination, including and explanation of the member's circumstances which warrant the immediate provision of nursing facility services unless HCBS are immediately available.

2.9.6.3.13.2 TENNCARE may request additional information as needed to confirm the CONTRACTOR's CEA determination and/or provider capacity to meet the member's needs, and shall, only upon receipt of satisfactory documentation, enroll the member in CHOICES.

2.9.6.3.14 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility services if HCBS are not immediately available; (3) determining whether the person wants nursing facility services if HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required.

2.9.6.3.15 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.3.16 TENNCARE will notify the CONTRACTOR via the 834 eligibility file when a person has been enrolled in CHOICES and, if the member is enrolled in CHOICES, the member's CHOICES Group. For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and see Section 2.6.1.5.2.3). For members in CHOICES Group 1, TENNCARE will notify the CONTRACTOR of applicable patient liability amounts (see Section 2.6.7.2).

2.9.6.3.17 The CONTRACTOR shall, within five (5) calendar days of notice of the member's enrollment in CHOICES, authorize and initiate long-term care services.

2.9.6.3.17.1 For purposes of the CHOICES program, service authorizations shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR is responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, shall select an alternative provider who is able to initiate services as authorized on or before the requested start date.

2.9.6.3.17.2 The CONTRACTOR shall provide at least verbal notice to the member prior to initiation of HCBS identified in the plan of care regarding any change in providers selected by the member for each HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a member in the nursing facility or community-based residential alternative setting requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.

2.9.6.3.17.3 If the CONTRACTOR is unable to initiate any long-term care service within the timeframes specified in this Agreement, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.3.17.4 For members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving nursing facility or community-based residential alternative services from a contract provider, the CONTRACTOR shall authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving services in a nursing facility or community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a

facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

2.9.6.3.17.5 For members receiving nursing facility services, the care coordinator shall participate as appropriate in the nursing facility's care planning process (see Section 2.9.6.5.1) and may supplement the plan of care as necessary (see Section 2.9.6.6.1).

2.9.6.3.17.6 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility and is enrolled in Group 2 or 3.

2.9.6.3.17.7 The CONTRACTOR shall ensure that all PASRR requirements are met prior to a member's admission to a nursing facility.

2.9.6.3.17.8 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless: (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.3.17.9 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1.

2.9.6.3.18 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities for persons when there is a waiting list, which may include at the time of CHOICES implementation.

2.9.6.4 <u>Care Coordination upon Enrollment in CHOICES</u>

2.9.6.4.1 Upon notice of a member's enrollment in CHOICES, the CONTRACTOR shall assume responsibility for all care coordination functions and activities described herein (assessment and care planning activities for members currently enrolled with the CONTRACTOR shall begin prior to CHOICES enrollment; see Section 2.9.6.3).

2.9.6.4.2 The CONTRACTOR shall be responsible for all aspects of care coordination and all requirements pertaining thereto, including but not limited to requirements set forth in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TENNCARE policies and protocols.

2.9.6.4.3 The CONTRACTOR shall assign to each member a specific care coordinator who shall have primary responsibility for performance of care coordination activities as specified in this Agreement, and who shall be the member's point of contact for coordination of all physical health, behavioral health, and long-term care services.

2.9.6.4.3.1 For CHOICES members, who are, upon CHOICES enrollment, receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific care coordinator prior to the first face-to-face visit required in this Agreement. If the first face-to-face visit will not occur within the first ten (10) days of the member's enrollment in CHOICES, the CONTRACTOR shall send the member written notification within ten (10) calendar days of the member's enrollment that explains how the member can reach the care coordination unit for assistance with concerns or questions pending the assignment of a specific care coordinator.

2.9.6.4.3.2 For CHOICES members who, upon enrollment in CHOICES, are not receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific care coordinator and shall advise the member of the name of his/her care coordinator and provide contact information prior to the initiation of services (see Section 2.9.6.2.4.4 and 2.9.6.2.5.3), but no more than ten (10) calendar days following CHOICES enrollment.

2.9.6.4.4 The CONTRACTOR may utilize a care coordination team approach to performing care coordination activities prescribed in Section 2.9.6. For each CHOICES member, the CONTRACTOR's care coordination team shall consist of the member's care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of CHOICES members. Care coordination teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling CHOICES care coordination functions. The CONTRACTOR shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams; the tasks that will be performed directly by the care coordinator; measures taken to ensure that the care coordinator remains the member's primary point of contact for the CHOICES program and related issues; escalation procedures to elevate issues to the care coordinator in a timely manner; and measures taken to ensure that if a member needs to reach his/her care coordinator specifically, calls that require immediate attention by a care coordinator are handled by a care coordinator and calls that do not require immediate attention are returned by the member's care coordinator the next business day.

2.9.6.5 Needs Assessment

2.9.6.5.1 *For Members in CHOICES Group 1*

2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a care coordinator shall conduct any needs assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. The care coordinator shall assess the member's potential for and interest in transition to the community and ensure coordination of the member's physical health, behavioral health, and long-term care needs. This assessment may include identification of targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining functional abilities, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit.

2.9.6.5.1.2 Needs reassessments shall be conducted as the care coordinator deems necessary.

2.9.6.5.2 *For Members in CHOICES Groups 2 and 3*

2.9.6.5.2.1 The care coordinator shall conduct a comprehensive needs assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE as part of its face-to-face visit with new members in CHOICES Groups 2 and 3 (see Section 2.9.6.2.5) and as part of its face-to-face intake visit for current members applying for CHOICES Groups 2 and 3.

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive needs assessment shall assess: (1) the member's physical, behavioral, functional, and psychosocial needs, including an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment; (2) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; and (3) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community and to delay or prevent the need for institutional placement.

2.9.6.5.2.3 The comprehensive needs assessment shall be conducted at least annually and as the care coordinator deems necessary.

2.9.6.5.2.4 For CHOICES Group 2 and 3 members, the CONTRACTOR shall visit the member face-to-face within five (5) business days of becoming aware that the member has a significant change in needs or circumstances as defined in Section 2.9.6.9.2.1.16 The care coordinator shall assess the member's needs, conduct a comprehensive needs assessment and update the member's plan of care as deemed necessary based on the member's circumstances.

2.9.6.6 Plan of Care

2.9.6.6.1 *For Members in CHOICES Group 1*

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator/care coordination team may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the plan of care as necessary with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's file.

2.9.6.6.1.2 The member's care coordinator shall participate as appropriate in the nursing facility's care planning process and advocate for the member.

2.9.6.6.1.3 The member's care coordinator/care coordination team shall be responsible for coordination of the member's physical health, behavioral health, and long-term care needs, which shall include coordination with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit.

2.9.6.6.2 *For Members in CHOICES Groups 2 and 3*

2.9.6.6.2.1 For members in CHOICES Groups 2 and 3, the care coordinator shall coordinate and facilitate a care planning team that includes, at a minimum, the member and the member's care coordinator. As appropriate, the care coordinator shall include or seek input from other individuals such as the member's representative or other persons authorized by the member to assist with needs assessment and care planning activities.

2.9.6.6.2.2 The CONTRACTOR shall ensure that care coordinators consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the plan of care.

2.9.6.6.2.3 The care coordinator shall verify that the decisions made by the care planning team are documented in a written, comprehensive plan of care.

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will

receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled on the basis of Immediate Eligibility who shall have access to services beyond the limited package of HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, and the schedule at which such care is needed, as applicable; 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 identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of HCBS specified in (5) above, excluding the cost of minor home modifications.

2.9.6.6.2.5 Within thirty (30) calendar days of notice of enrollment in CHOICES, for members in CHOICES Groups 2 and 3 the plan of care shall include, at a minimum, the following additional elements:

2.9.6.6.2.5.1 Description of the member's current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs;

2.9.6.6.2.5.2 Description of the member's physical environment and any modifications necessary to ensure the member's health and safety;

2.9.6.6.2.5.3 Description of medical equipment used or needed by the member (if applicable);

2.9.6.6.2.5.4 Description of any special communication needs including interpreters or special devices;

2.9.6.6.2.5.5 A description of the member's psychosocial needs, including any housing or financial assistance needs which could impact the member's ability to maintain a safe and healthy living environment;

2.9.6.6.2.5.6 Goals, objectives and desired health, functional, and quality of life outcomes for the member;

2.9.6.6.2.5.7 Description of other services that will be provided to the member, including (1) covered physical and behavioral health services that will be provided by the CONTRACTOR to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; (2) other social support services and assistance needed in order to ensure the

member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and (3) any non-covered services including services provided by other community resources, including plans to link the member to financial assistance programs including but not limited to housing, utilities and food as needed;

2.9.6.6.2.5.8 Relevant information from the member's individualized treatment plan for any member receiving behavioral health services (see Section 2.7.2.1.4 of this Agreement) that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of services;

2.9.6.6.2.5.9 Relevant information regarding the member's physical health condition(s), including treatment and medication regimen, that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care;

2.9.6.6.2.5.10 Frequency of planned care coordinator contacts needed, which shall include consideration of the member's individualized needs and circumstances, and which shall at minimum meet required contacts as specified in Section 2.9.6.9.4 (unplanned care coordinator contacts shall be provided as needed);

2.9.6.6.2.5.11 Additional information for members who elect consumer direction of HCBS, including but not limited to whether the member requires a representative to participate in consumer direction and the specific services that will be consumer directed;

2.9.6.6.2.5.12 If the member chooses to self-direct any health care tasks, the type of tasks that will be self-directed;

2.9.6.6.2.5.13 Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;

2.9.6.6.2.5.14 A disaster preparedness plan specific to the member; and

2.9.6.6.2.5.15 The member's TennCare eligibility end date.

2.9.6.6.2.6 The member's care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any updates.

2.9.6.6.2.6.1 The CONTRACTOR shall develop policies and procedures that describe the measures taken by the CONTRACTOR to address instances when a member refuses to sign the plan of care. The policies and procedures shall include a specific escalation process (ultimately to TENNCARE) that includes a review of the reasons for the member's refusal as well as actions taken to resolve any disagreements with the plan of care and shall involve the consumer advocate in helping to facilitate resolution.

2.9.6.6.2.6.2 When the refusal to sign is due to a member's request for additional services, including requests for a different type or an increased amount, frequency, scope, and/or duration of services than what is included in the plan of care, the CONTRACTOR shall, in the case of a new plan of care, authorize and initiate

services in accordance with the plan of care; and, in the case of an annual or revised plan of care, ensure continuation of at least the level of services in place at the time the annual or revised plan of care was developed until a resolution is reached, which may include resolution of a timely filed appeal, if applicable. The CONTRACTOR shall not use the member's acceptance of services as a waiver of the member's right to dispute the plan of care or as cause to stop the resolution process.

2.9.6.6.2.6.3 When the refusal to sign is due to the inclusion of services that the member does not want to receive, either in totality or in the amount, frequency, scope or duration of services in the plan of care, the care coordinator shall modify the risk agreement to note this issue, the associated risks, and the measures to mitigate the risks. The risk agreement shall be signed and dated by the member or his/her representative and the care coordinator. In the event the care coordinator determines that the member's needs cannot be safely and effectively met in the community without receiving these services, the CONTRACTOR may request that it no longer provide long-term care services to the member (see Section 2.6.1.5.8).

2.9.6.6.2.7 The member's care coordinator/care coordination team shall provide a copy of the member's completed plan of care, including any updates, to the member, the member's representative, as applicable, and the member's community residential alternative provider, as applicable. The member's care coordinator/care coordination team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such providers who do not receive a copy of the plan of care are informed in writing of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to the tasks and functions to be performed.

2.9.6.6.2.8 Within five (5) business days of completing a reassessment of a member's needs, the member's care coordinator/care coordination team shall update the member's plan of care as appropriate, and the CONTRACTOR shall authorize and initiate HCBS in the updated plan of care. The CONTRACTOR shall comply with requirements for service authorization in Section 2.9.6.2.5.10, change of provider in Section 2.9.6.2.5.11, and notice of service delay in Section 2.9.6.2.5.12.

2.9.6.6.2.9 The member's care coordinator shall inform each member of his/her eligibility end date and educate members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members will be contacted by TENNCARE or its designee near the date a redetermination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

2.9.6.7 <u>Nursing Facility Diversion</u>

2.9.6.7.1 The CONTRACTOR shall develop and implement a nursing facility diversion process that complies with the requirements in this Section 2.9.6.7 and is prior approved in writing by TENNCARE. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary and requested by the member.

2.9.6.7.2 At a minimum the CONTRACTOR's diversion process shall target the following groups for diversion activities:

2.9.6.7.2.1 Members in CHOICES Group 1 who are waiting for placement in a nursing facility;

2.9.6.7.2.2 CHOICES members residing in their own homes who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

2.9.6.7.2.3 CHOICES members residing in adult care homes or other community-based residential alternative settings who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

2.9.6.7.2.4 CHOICES and non-CHOICES members admitted to an inpatient hospital or inpatient rehabilitation who are not residents of a nursing facility; and

2.9.6.7.2.5 CHOICES and non-CHOICES members who are placed short-term in a nursing facility regardless of payer source.

2.9.6.7.3 The CONTRACTOR's nursing facility diversion process shall be tailored to meet the needs of each group identified in Section 2.9.6.7.2 above.

2.9.6.7.4 The CONTRACTOR's nursing facility diversion process shall include a detailed description of how the CONTRACTOR will work with providers (including hospitals regarding notice of admission and discharge planning; see Sections 2.9.6.3.4 and 2.9.6.3.11) to ensure appropriate communication among providers and between providers and the CONTRACTOR, training for key CONTRACTOR and provider staff, early identification of members who may be candidates for diversion (both CHOICES and non-CHOICES members), and follow-up activities to help sustain community living.

2.9.6.7.5 The CONTRACTOR's nursing facility diversion process shall include specific timelines for each identified activity.

2.9.6.8 <u>Nursing Facility-to-Community Transition</u>

2.9.6.8.1 The CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

2.9.6.8.1.1 Starting on the date of implementation of CHOICES in the Grand Region covered by this Agreement, referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;

2.9.6.8.1.2 Starting on the date of implementation of CHOICES in the Grand Region covered by this Agreement, identification through the care coordination process,

including but not limited to: assessments, information gathered from nursing facility staff or participation in Grand Rounds (as defined in Section 1); and

2.9.6.8.1.3 Upon notice from TENNCARE but no more than one hundred and twenty (120) days following the implementation of CHOICES in the Grand Region covered by this Agreement, review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.

2.9.6.8.2 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral the CONTRACTOR conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.3 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification the CONTRACTOR conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.4 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections 2.9.6.8.2 and 2.9.6.8.3 above) or within fourteen (14) days of identification through the care coordination process, the care coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.

2.9.6.8.5 As part of the transition assessment, the care coordinator shall conduct a risk assessment using a tool and protocol specified by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall begin to develop, as applicable, a risk agreement that shall be signed by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk as part of the plan of care. The risk agreement shall include the frequency and type of care coordinator contacts that exceed the minimum contacts required (see Section 2.9.6.9.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. The member's care coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and

effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator/care coordination team shall explain to the member the individual cost neutrality cap and notification process and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the CONTRACTOR will assist with transition to a more appropriate care delivery setting.

2.9.6.8.6 For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator shall notify them in accordance with the specified transition assessment protocol.

2.9.6.8.7 For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.

2.9.6.8.8 The care coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.

2.9.6.8.9 As part of transition planning, prior to the member's physical move to the community, the care coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections 2.9.6.8.18 and 2.9.6.8.17.

2.9.6.8.10 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

2.9.6.8.11 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.

2.9.6.8.12 The member's care coordinator shall also complete a plan of care that meets all criteria described in Section 2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive needs assessment, completing and signing the risk agreement and making a final determination of cost neutrality. The plan of care shall be authorized and initiated prior to the member's transition to the community.

2.9.6.8.13 The CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).

2.9.6.8.14 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 effective as of the planned transition date.

2.9.6.8.15 The member's care coordinator shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.

2.9.6.8.16 For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care, and shall take immediate action to resolve any service gaps (see definition in Section 1).

2.9.6.8.17 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the care coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.

2.9.6.8.18 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the care coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the care coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the care coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

2.9.6.8.19 The member's care coordinator shall monitor hospitalizations and short-term nursing facility stays for members who transition to identify and address issues that may prevent the member's long-term community placement.

2.9.6.8.20 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.

2.9.6.8.21 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions.

2.9.6.8.22 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.

2.9.6.9 Ongoing Care Coordination

2.9.6.9.1 *For Members in CHOICES Group 1*

2.9.6.9.1.1 The CONTRACTOR shall provide for the following ongoing care coordination to CHOICES members in Group 1:

2.9.6.9.1.1.1 Develop protocols and processes to work with nursing facilities to coordinate the provision of care. At minimum, a care coordinator assigned to a resident of the nursing facility shall participate in quarterly Grand Rounds (as defined in Section 1). At least two of the Grand Rounds per year shall be conducted on-site in the facility, and the Grand Rounds shall identify and address any member who has experienced a potential significant change in needs or circumstances (see Section 2.9.6.9.1.1.5) or about whom the nursing facility or MCO has expressed concerns;

2.9.6.9.1.1.2 Develop and implement targeted strategies to improve health, functional, or quality of life outcomes, e.g., related to disease management or pharmacy management, or to increase and/or maintain functional abilities;

2.9.6.9.1.1.3 Coordinate with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic health conditions, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit;

2.9.6.9.1.1.4 Intervene and address issues as they arise regarding payment of patient liability amounts and assist in interventions to address untimely or non-payment of patient liability in order to avoid the consequences of non-payment; and

2.9.6.9.1.1.5 At a minimum, the CONTRACTOR shall consider the following a potential significant change in needs or circumstances for CHOICES Group 1 members who are residing in a nursing facility and contact the nursing facility to determine if a visit and reassessment is needed:

2.9.6.9.1.1.5.1 Pattern of recurring falls;

2.9.6.9.1.1.5.2 Incident, injury or complaint;

2.9.6.9.1.1.5.3 Report of abuse or neglect;

2.9.6.9.1.1.5.4 Frequent hospitalizations; or

2.9.6.9.1.1.5.5 Prolonged or significant change in health and/or functional status.

2.9.6.9.2 *For Members in CHOICES Groups 2 and 3*

2.9.6.9.2.1 The CONTRACTOR shall provide for the following ongoing care coordination to CHOICES members in Groups 2 and 3:

2.9.6.9.2.1.1 Coordinate a care planning team, developing a plan of care and updating the plan as needed;

2.9.6.9.2.1.2 During the development of the member's plan of care and as part of the annual updates, the care coordinator shall discuss with the member his/her interest in consumer direction of HCBS;

2.9.6.9.2.1.3 During the development of the member's plan of care, the care coordinator shall educate the member about his/her ability to use advance directives and document the member's decision in the member's file;

2.9.6.9.2.1.4 Ensure the plan of care addresses the member's desired outcomes, needs and preferences;

2.9.6.9.2.1.5 For members in CHOICES Group 2, each time a member's plan of care is updated to change the level or type of service, document in accordance with TENNCARE policy that the projected total cost of HCBS, home health care and private duty nursing is less than the member's cost neutrality cap. The CONTRACTOR shall monitor utilization to identify members who may exceed the cost neutrality cap and to intervene as necessary to maintain the member's community placement. The CONTRACTOR shall also educate members in CHOICES Group 2 about the cost neutrality cap and what will happen if the cap is met;

2.9.6.9.2.1.6 For members in CHOICES Group 3, determine whether the cost of HCBS, excluding minor home modifications, will exceed the expenditure cap for CHOICES Group 3. The CONTRACTOR shall continuously monitor a member's expenditures and work with the member when he/she is approaching the limit including identifying non-long term care services that will be provided when the limit has been met to prevent/delay the need for institutionalization. Each time the plan of care for a member in CHOICES Group 3 is updated, the CONTRACTOR shall educate the member about the expenditure cap;

2.9.6.9.2.1.7 For new services in an updated plan of care, the care coordinator shall provide the member with information about potential providers for each HCBS that will be provided by the CONTRACTOR and assist members with any requests for information that will help the member in choosing a provider and, if applicable, in changing providers, subject to the provider's capacity and willingness to provide service;

2.9.6.9.2.1.8 Upon the scheduled initiation of services identified in the plan of care, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs;

2.9.6.9.2.1.9 Identify and address service gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner;

2.9.6.9.2.1.10 Identify changes to member's risk, address those changes and update the member's risk agreement as necessary;

2.9.6.9.2.1.11 Reassess a member's needs and update a member's plan of care in accordance with requirements and timelines specified Sections 2.9.6.5 and 2.9.6.6;

2.9.6.9.2.1.12 Maintain appropriate on-going communication with community and natural supports to monitor and support their ongoing participation in the member's care;

2.9.6.9.2.1.13 For services not covered by the CONTRACTOR, coordinate with community organizations that provide services that are important to the health, safety and well-being of members. This may include but shall not be limited to referrals to other agencies for assistance and assistance as needed with applying for programs, but the CONTRACTOR shall not be responsible for the provision or quality of non-covered services provided by other entities;

2.9.6.9.2.1.14 Notify TENNCARE immediately, in the manner specified by TENNCARE, if the CONTRACTOR determines that the needs of a member in CHOICES Group 2 cannot be met safely in the community and within the member's cost neutrality cap;

2.9.6.9.2.1.15 Perform additional requirements for consumer direction of HCBS as specified in Section 2.9.6.10; and

2.9.6.9.2.1.16 At a minimum, the CONTRACTOR shall consider the following a significant change in needs or circumstances for members in CHOICES Groups 2 and 3 residing in the community:

2.9.6.9.2.1.16.1 Change of residence or primary caregiver or loss of essential social supports;

2.9.6.9.2.1.16.2 Significant change in health and/or functional status;

2.9.6.9.2.1.16.3 Loss of mobility;

2.9.6.9.2.1.16.4 An event that significantly increases the perceived risk to a member; or

2.9.6.9.2.1.16.5 Member has been referred to APS because of abuse, neglect or exploitation.

2.9.6.9.2.1.17 Identify and immediately respond to problems and issues including but not limited to circumstances that would impact the member's ability to continue living in the community.

2.9.6.9.3 *For ALL CHOICES Members*

2.9.6.9.3.1 The CONTRACTOR shall provide for the following ongoing care coordination to all CHOICES members:

2.9.6.9.3.1.1 Conduct a level of care reassessment at least annually and within five (5) business days of the CONTRACTOR's becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility.

2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care or if the assessment was prompted by a request by a member, a member's representative or caregiver or another entity for a change in level of services, the assessment shall be forwarded to TENNCARE for determination;

2.9.6.9.3.1.1.2 If the level of care assessment indicates no change in level of care, the CONTRACTOR shall document the date the level of care assessment completed in the member's file; any level of care assessments prompted by a request for a change in level of services shall be submitted to TENNCARE for determination.

2.9.6.9.3.1.2 Facilitate access to physical and/or behavioral health services as needed, including transportation to services as specified in Section 2.6.1 and Attachment XI; except as provided in Sections 2.11.1.8 or 2.6.5, transportation for HCBS is not included;

2.9.6.9.3.1.3 Monitor and ensure the provision of covered physical health, behavioral health, and/or long-term care services as well as services provided as a cost-effective alternative to other covered services and ensure that services provided meet the member's needs;

2.9.6.9.3.1.4 Provide assistance in resolving concerns about service delivery or providers;

2.9.6.9.3.1.5 Coordinate with a member's PCP, specialists and other providers, such as the member's mental health case manager, to facilitate a comprehensive, holistic, person-centered approach to care;

2.9.6.9.3.1.6 Contact providers and workers on a periodic basis and coordinate with providers and workers to collaboratively address issues regarding member service delivery and to maximize community placement strategies;

2.9.6.9.3.1.7 Share relevant information with and among providers and others when information is available and it is necessary to share for the well-being of the member;

2.9.6.9.3.1.8 Determine the appropriate course as specified herein upon (1) receipt of any contact made by or on behalf of a member, regardless of source, which asserts that the member's needs are not met by currently authorized services; (2) the member's hospitalization; or (3) other circumstances which warrant review and potential modification of services authorized for the member;

2.9.6.9.3.1.9 Ensure that all PASRR requirements are met prior to the member's admission to a nursing facility;

2.9.6.9.3.1.10 Update consent forms as necessary; and

2.9.6.9.3.1.11 Assure that the organization of and documentation included in the member's file meets all applicable CONTRACTOR standards.

2.9.6.9.3.2 The CONTRACTOR shall provide to contract providers, including but not limited to hospitals, nursing facilities, physicians, and behavioral health providers, and caregivers information regarding the role of the care coordinator and shall request providers and caregivers to notify a member's care coordinator, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. The CONTRACTOR shall provide training to key providers and caregivers regarding the value of this communication and remind them that the member identification card indicates if a member is enrolled in CHOICES.

2.9.6.9.3.3 The CONTRACTOR shall have systems in place to facilitate timely communication between internal departments and the care coordinator to ensure that each care coordinator receives all relevant information regarding his/her members, e.g., member services, disease management, utilization management, and claims processing. The care coordinator shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.

2.9.6.9.3.4 The CONTRACTOR shall monitor and evaluate a member's emergency department and behavioral health crisis service utilization to determine the reason for these visits. The care coordinator shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, and/or updating the member's plan of care and to better manage the member's physical health or behavioral health condition(s).

2.9.6.9.3.5 The CONTRACTOR shall develop policies and procedures to ensure that care coordinators are actively involved in discharge planning when a CHOICES member is hospitalized. The CONTRACTOR shall define circumstances that require that hospitalized CHOICES members receive a face-to-face visit to complete a needs reassessment and an update to the member's plan of care as needed.

2.9.6.9.3.6 The CONTRACTOR shall ensure that at each face-to-face visit the care coordinator makes the following observations and documents the observations in the member's file:

2.9.6.9.3.6.1 Member's physical condition including observations of the member's skin, weight changes and any visible injuries;

2.9.6.9.3.6.2 Member's physical environment;

2.9.6.9.3.6.3 Member's satisfaction with services and care;

2.9.6.9.3.6.4 Member's upcoming appointments;

2.9.6.9.3.6.5 Member's mood and emotional well-being;

2.9.6.9.3.6.6 Member's falls and any resulting injuries;

2.9.6.9.3.6.7 A statement by the member regarding any concerns or questions; and

2.9.6.9.3.6.8 A statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available).

2.9.6.9.3.7 The CONTRACTOR shall identify and immediately respond to problems and issues including but not limited to:

2.9.6.9.3.7.1 Service gaps; and

2.9.6.9.3.7.2 Complaints or concerns regarding the quality of care rendered by providers, workers, or care coordination staff.

2.9.6.9.4 *Minimum Care Coordinator Contacts*

2.9.6.9.4.1 The care coordinator shall conduct all needs assessment and care planning activities, and shall make all minimum care coordinator contacts as specified below in the member's place of residence, except under extenuating circumstances (such as assessment and care planning conducted during the member's hospitalization, or upon the member's request), which shall be documented in writing.

2.9.6.9.4.1.1 While the CONTRACTOR may grant a member's request to conduct certain care coordination activities outside his or her place of residence, the CONTRACTOR is responsible for assessing the member's living environment in order to identify any modifications that may be needed and to identify and address, on an ongoing basis, any issues which may affect the member's health, safety and welfare. Repeated refusal by the member to allow the care coordinator to conduct visits in his or her home may, subject to review and approval by TENNCARE, constitute grounds for disenrollment from CHOICES Groups 2 or 3, if the CONTRACTOR is unable to properly perform monitoring and other contracted functions and to confirm that the member's needs can be safely and effectively met in the home setting.

2.9.6.9.4.2 A member may initiate a request to opt out of some of the minimum face-to-face contacts, but only with TENNCARE review of circumstances and approval. The CONTRACTOR shall not encourage a member to request a reduction in face-to-face visits by the care coordinator.

2.9.6.9.4.3 The CONTRACTOR shall ensure that care coordinators assess each member's need for contact with the care coordinator, to meet the member's individual need and ensure the member's health and welfare. At a minimum, CHOICES members shall be contacted by their care coordinator according to the following timeframes:

2.9.6.9.4.3.1 Members shall receive a face-to-face visit from their care coordinator in their residence within the timeframes specified in Sections 2.9.6.2.4, 2.9.6.2.5 and 2.9.6.3.

2.9.6.9.4.3.2 Members who are newly admitted to a nursing facility when the admission has not been authorized by the CONTRACTOR, shall receive a face-to-face visit from their care coordinator within ten (10) days of notification of admission.

2.9.6.9.4.3.3 Members in CHOICES Group 2 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section 2.9.6.8.

2.9.6.9.4.3.4 Within five (5) business days of scheduled initiation of services, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 who begin receiving HCBS after the date of enrollment in CHOICES to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.9.4.3.5 Within five (5) business days of scheduled initiation of HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.9.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) shall receive a face-to-face visit from their care coordinator at least twice a year at a reasonable interval.

2.9.6.9.4.3.7 Members in CHOICES Group 2 shall be contacted by their care coordinator at least monthly either in person or by telephone. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly.

2.9.6.9.4.3.8 Members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly either in person or by telephone. These members shall be visited in their residence face-to-face by their care coordinator a minimum of semi-annually.

2.9.6.9.5 The CONTRACTOR shall ensure a member's care coordinator/care coordination team coordinates with Medicare payers, Medicare Advantage plans, and Medicare

providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare (see Section 2.9.12).

2.9.6.9.6 *Member Case Files*

2.9.6.9.6.1 The care coordinator/care coordination team shall maintain individual files for each assigned CHOICES member.

2.9.6.9.6.2 For members in CHOICES Group 1, the files shall contain at a minimum:

2.9.6.9.6.2.1 Pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information;

2.9.6.9.6.2.2 Any supplements to the nursing facility plan of care, as applicable;

2.9.6.9.6.2.3 A signed acknowledgement of the member's patient liability amount and the member's understanding regarding his/her responsibility with respect to payment of patient liability, including the potential consequences for non-payment; and

2.9.6.9.6.2.4 Transition assessment and transition plan, if applicable.

2.9.6.9.6.3 For members in CHOICES Groups 2 or 3, the files shall contain at a minimum:

2.9.6.9.6.3.1 The most current plan of care, including the detailed plan for back-up providers in situations when regularly scheduled providers are unavailable or do not arrive as scheduled;

2.9.6.9.6.3.2 List of providers who will be providing home health, private duty nursing and HCBS paid for by other payors;

2.9.6.9.6.3.3 Written confirmation of the member's decision regarding participation in consumer direction of HCBS;

2.9.6.9.6.3.4 For members who are self-directing any health care tasks, a copy of the physician's order;

2.9.6.9.6.3.5 For members in CHOICES Group 2, a completed risk assessment and a risk agreement signed by the member or his/her representative; and documentation that the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including signed acknowledgement of understanding by the member or his/her representative that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2;

2.9.6.9.6.3.6 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, a determination by the CONTRACTOR that the projected cost of

HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap, and signed acknowledgement of understanding by the member or his/her representative that a change in his/her needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2 ; and

2.9.6.9.6.3.7 For members in CHOICES Group 3, signed acknowledgement regarding the expenditure cap.

2.9.6.9.6.4 For all CHOICES members, files shall contain at a minimum:

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;

2.9.6.9.6.4.2 Evidence that a care coordinator/the care coordination team provided the member with CHOICES member education materials (see Section 2.17.7 of this Agreement), reviewed the materials, and provided assistance with any questions;

2.9.6.9.6.4.3 Evidence that a care coordinator/the care coordination team provided the member with education about the member's ability to use an advance directive and documentation of the member's decision;

2.9.6.9.6.4.4 The most recent level of care assessment and needs assessment (if applicable);

2.9.6.9.6.4.5 Documentation of the member's choice of contract providers for long-term care services;

2.9.6.9.6.4.6 Signed consent forms as necessary in order to share confidential information with and among providers consistent with all applicable state and federal laws and regulations;

2.9.6.9.6.4.7 A list of emergency contacts approved by the member;

2.9.6.9.6.4.8 Documentation of observations completed during face-to-face contact by the care coordinator; and

2.9.6.9.6.4.9 The member's TennCare eligibility end date.

2.9.6.10 <u>Additional Requirements for Care Coordination Regarding Consumer Direction of HCBS</u>

2.9.6.10.1 In addition to the roles and responsibilities otherwise specified in this Section 2.9.6, the CONTRACTOR shall ensure that the following additional care coordination functions related to consumer direction of HCBS are fulfilled.

2.9.6.10.2 The CONTRACTOR shall be responsible for providing all needed eligible HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section

2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.6.10.3 If a member is interested in participating in consumer direction of HCBS and the member does not intend to appoint a representative, the care coordinator shall determine the extent to which the member may require assistance to direct his/her services (see Section 2.9.7.4.5). If the care coordinator determines that the member requires assistance to direct his/her services, based upon the results of a completed self-assessment instrument developed by TENNCARE, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf (see Section 2.9.7.4.5.1).

2.9.6.10.4 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1) and that a representative agreement is completed and signed by the member prior to forwarding a referral to the FEA (see Section 2.9.7.4.7).

2.9.6.10.5 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member does not use a representative, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of HCBS.

2.9.6.10.6 The care coordinator, in conjunction with the FEA, shall assist the member and/or the representative as needed in developing a back-up plan for consumer direction that adequately identifies how the member will address situations when a scheduled worker fails to show up. The member and his/her representative (as applicable) shall have primary responsibility for the development of the back-up plan for consumer directed services. The back-up plan shall include the names and telephone number of contacts for alternate care, the order in which contact shall be made and the services to be provided by contacts. Back-up workers may include paid and non-paid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up staff who are willing and available to serve in this capacity. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction. All persons and/or organizations noted in back-up plan for consumer directed services shall first be contacted by the member and/or representative to determine their willingness and availability to serve as back-up workers. The care coordinator shall follow-up with these persons and/or organizations to confirm their willingness and availability to provide care when needed.

2.9.6.10.7 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the member's supports broker is invited to participate in these meetings.

2.9.6.10.8 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization

for consumer directed services for that member. Each authorization for consumer directed services shall include the required elements for a referral (see Section 2.9.7.4.7) including: authorized service, authorized units of service, including amount, frequency and duration, start and end dates, and service code.

2.9.6.10.9 The member's care coordinator/care coordination team shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction of HCBS (see Section 2.9.7.3.4).

2.9.6.10.10 The CONTRACTOR shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.

2.9.6.10.11 The care coordinator shall determine a member's interest in enrolling in or continuing to participate in consumer direction annually and shall document the member's decision in the member's plan of care.

2.9.6.10.12 If at any time the care coordinator or FEA suspects abuse or neglect on the part of the representative or worker, the care coordinator and/or FEA shall report the allegations to the CONTRACTOR. The CONTRACTOR shall report the representative and/or worker to APS. The representative and/or worker shall immediately be released from his/her duties until the APS investigation is complete. The care coordinator shall work with the member to find a new representative, and the FEA shall work with the member to find a suitable replacement worker. If the allegations are substantiated as a result of the APS investigation, the representative and/or worker shall no longer be allowed to participate in the CHOICES program in any capacity.

2.9.6.10.13 In the event the CONTRACTOR believes that it cannot safely and effectively serve the member in the community, the care coordinator, with the assistance of and input from the FEA, shall review with the member the previously developed risk agreement and update it to ensure that any additional identified risks are incorporated and measures are identified to mitigate risks. The representative (if applicable) shall participate in the process. The updated risk assessment shall be signed by the member or representative and the care coordinator. A copy shall be given to the member or representative. The care coordinator and the FEA shall file a copy in the member's files. If the CONTRACTOR does not believe the member can be safely and effectively served in the community, the CONTRACTOR may request to involuntarily withdraw the member from consumer direction of HCBS (see Section 2.9.7.9).

2.9.6.11 <u>Care Coordination Staff</u>

2.9.6.11.1 The CONTRACTOR shall establish qualifications for care coordinators. At a minimum, care coordinators shall be an RN or LPN or have a bachelor's degree in social work, nursing or other health care profession. A care coordinator's direct supervisor shall be a licensed social worker or registered nurse with a minimum of two (2) years of relevant health care (preferably long-term care) experience.

2.9.6.11.2 If the CONTRACTOR elects to use a care coordination team, the CONTRACTOR's policies and procedures shall specify the qualifications, experience and training of each member of the team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator (see Section 2.9.6.4.4).

2.9.6.11.3 The CONTRACTOR shall ensure an adequate number of care coordinators are available and that sufficient staffing ratios are maintained to address the needs of CHOICES members and meet all the requirements described in this Agreement.

2.9.6.11.4 The CONTRACTOR shall monitor staffing ratios and adjust ratios as necessary to ensure that care coordinators are able to meet the requirements of this Agreement and address members' needs.

2.9.6.11.5 While care coordination staffing ratios are not specified, the CONTRACTOR shall submit to TennCare for review and approval at least 120 days in advance of CHOICES implementation in the Grand Region covered by this Agreement a Care Coordination Staffing Plan, which shall specify the number of care coordinators, care coordination supervisors, other care coordination team members the CONTRACTOR plans to initially employ, the ratio of care coordinators to members the CONTRACTOR plans to maintain, an explanation of the methodology for determining such ratio, and how the CONTRACTOR will ensure that such ratios are sufficient to fulfill the requirements specified in this Agreement and roles and responsibilities for each member of the care coordination team. TENNCARE shall notify the CONTRACTOR in writing if the Care Coordination Staffing Plan is insufficient and may require modifications to ensure, prior to implementation of CHOICES, that the CONTRACTOR has sufficient care coordination staff. After CHOICES has been implemented, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Care Coordination Staffing Plan, including a variance of twenty (20) percent or more from the planned staffing ratio. TENNCARE may request changes in the CONTRACTOR's Care Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient care coordination staff to properly and timely perform its obligations under this Agreement.

2.9.6.11.6 The CONTRACTOR shall establish a system to assign care coordinators and to notify the member of his/her assigned care coordinator's name and contact information in accordance with Section 2.9.6.4.3.

2.9.6.11.7 The CONTRACTOR shall ensure that members have a telephone number to call to directly contact (without having to disconnect or place a second call) their care coordinator or a member of their care coordination team (if applicable) during normal business hours. If the member's care coordinator or a member of the member's care coordination team is not available, the call shall be answered by another qualified staff person in the care coordination unit. If the call requires immediate attention from a care coordinator, the staff member answering the call shall immediately transfer the call to the member's care coordinator (or another care coordinator if the member's care coordinator is not available) as a "warm transfer" (see definition in Section 1). After normal business hours, calls that require immediate attention by a care coordinator shall be transferred to a care coordinator as specified in Section 2.18.1.6.

2.9.6.11.8 The CONTRACTOR shall permit members to change to a different care coordinator if the member desires and there is an alternative care coordinator available. Such availability may take into consideration the CONTRACTOR's need to efficiently deliver care coordination in accordance with requirements specified herein, including

for example, the assignment of a single care coordinator to all CHOICES members receiving nursing facility or community-based residential alternative services from a particular provider. Subject to the availability of an alternative care coordinator, the CONTRACTOR may impose a six (6) month lock-in period with an exception for cause after a member has been granted one (1) change in care coordinators.

2.9.6.11.9 In order to ensure quality and continuity of care, the CONTRACTOR shall make efforts to minimize the number of changes in care coordinator assigned to a member. A CONTRACTOR initiated change in care coordinators may be appropriate in the following circumstances:

2.9.6.11.9.1 Care coordinator is no longer employed by the CONTRACTOR;

2.9.6.11.9.2 Care coordinator has a conflict of interest and cannot serve the member;

2.9.6.11.9.3 Care coordinator is on temporary leave from employment; and

2.9.6.11.9.4 Care coordinator caseloads must be adjusted due to the size or intensity of an individual care coordinator's caseload.

2.9.6.11.10 The CONTRACTOR shall develop policies and procedures regarding notice to members of care coordinator changes initiated by either the CONTRACTOR or the member, including advance notice of planned care coordinator changes initiated by the CONTRACTOR.

2.9.6.11.11 The CONTRACTOR shall ensure continuity of care when care coordinator changes are made whether initiated by the member or by the CONTRACTOR. The CONTRACTOR shall demonstrate use of best practices by encouraging newly assigned care coordinators to attend a face-to-face transition visit with the member and the out-going care coordinator when possible.

2.9.6.11.12 The CONTRACTOR shall provide initial training to newly hired care coordinators and ongoing training at least annually to care coordinators. Initial training topics shall include at a minimum:

2.9.6.11.12.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3, including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, the expenditure cap for Group 3, and the limited benefit package for members enrolled on the basis of Immediate Eligibility;

2.9.6.11.12.2 Facilitating CHOICES enrollment for current members;

2.9.6.11.12.3 Level of care and needs assessment and reassessment, development of a plan of care, and updating the plan of care including training on the tools and protocols;

2.9.6.11.12.4 Development and implementation of back-up plans;

2.9.6.11.12.5 Consumer direction of HCBS;

2.9.6.11.12.6 Self-direction of health care tasks;

2.9.6.11.12.7 Coordination of care for duals;

2.9.6.11.12.8 Electronic visit verification;

2.9.6.11.12.9 Conducting a home visit and use of the monitoring checklist;

2.9.6.11.12.10 How to immediately identify and address service gaps;

2.9.6.11.12.11 Management of critical transitions (including hospital discharge planning);

2.9.6.11.12.12 Nursing facility diversion;

2.9.6.11.12.13 Nursing facility to community transitions, including training on tools and protocols;

2.9.6.11.12.14 For members in CHOICES Group 1, members' responsibility regarding patient liability, including the consequences of not paying patient liability;

2.9.6.11.12.15 Alzheimer's, dementia and cognitive impairments;

2.9.6.11.12.16 Traumatic brain injury;

2.9.6.11.12.17 Physical disabilities;

2.9.6.11.12.18 Disease management;

2.9.6.11.12.19 Behavioral health;

2.9.6.11.12.20 Evaluation and management of risk;

2.9.6.11.12.21 Identifying and reporting abuse/neglect (see Section 2.24.4);

2.9.6.11.12.22 Fraud and abuse, including reporting fraud and abuse;

2.9.6.11.12.23 Advance directives and end of life care;

2.9.6.11.12.24 HIPAA;

2.9.6.11.12.25 Cultural competency;

2.9.6.11.12.26 Disaster planning; and

2.9.6.11.12.27 Available community resources for non-covered services.

2.9.6.11.13 The CONTRACTOR shall establish roles and job responsibilities for care coordinators. The job responsibilities shall include a description of activities and required timeframes for completion. These activities shall include the requirements specified in this Section 2.9.6.

2.9.6.12 Care Coordination Monitoring

2.9.6.12.1 The CONTRACTOR shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination processes. The CONTRACTOR shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediations to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. At a minimum, the CONTRACTOR shall ensure that:

2.9.6.12.1.1 Care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;

2.9.6.12.1.2 Level of care assessments and reassessments occur on schedule and are submitted to TENNCARE in accordance with requirements in Section 2.9.6.9.3.1.1;

2.9.6.12.1.3 Needs assessments and reassessment, as applicable, occur on schedule and in compliance with this Agreement;

2.9.6.12.1.4 Plans of care for CHOICES Groups 2 and 3 are developed and updated on schedule and in compliance with this Agreement;

2.9.6.12.1.5 Plans of care for CHOICES Groups 2 and 3 reflect needs identified in the needs assessment and reassessment process;

2.9.6.12.1.6 Plans of care for CHOICES Groups 2 and 3 are appropriate and adequate to address member needs;

2.9.6.12.1.7 Services are delivered as described in the plan of care and authorized by the CONTRACTOR;

2.9.6.12.1.8 Services are appropriate to address the member's needs;

2.9.6.12.1.9 Services are delivered in a timely manner;

2.9.6.12.1.10 Service utilization is appropriate;

2.9.6.12.1.11 Service gaps are identified and addressed in a timely manner;

2.9.6.12.1.12 Minimum care coordinator contacts are conducted;

2.9.6.12.1.13 Care coordinator-to-member ratios are appropriate;

2.9.6.12.1.14 The cost neutrality cap for members in CHOICES Group 2 and the expenditure cap for members in CHOICES Group 3 are monitored and appropriate action is taken if a member is nearing or exceeds his/her cost neutrality or expenditure cap; and

2.9.6.12.1.15 That benefit limits are monitored and that appropriate action is taken if a member is nearing or exceeds a benefit limit.

2.9.6.12.2 The CONTRACTOR shall provide to TENNCARE the reports required by Section 2.30.

2.9.6.12.3 The CONTRACTOR shall purchase and implement an electronic visit verification system to monitor member receipt and utilization of HCBS including at a minimum, personal care, attendant care, homemaker services and home-delivered meals. The CONTRACTOR shall select its own electronic visit verification vendor and shall ensure, in the development of such system, the following minimal functionality:

2.9.6.12.3.1 The ability to log the arrival and departure of individual provider staff person or consumer direction worker;

2.9.6.12.3.2 The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home);

2.9.6.12.3.3 The ability to verify the identity of the individual provider staff person or worker providing the service to the member;

2.9.6.12.3.4 The ability to match services provided to a member with services authorized in the plan of care;

2.9.6.12.3.5 The ability to ensure that the provider/worker delivering the service is authorized to deliver such services;

2.9.6.12.3.6 The ability to establish a schedule of services for each member which identifies the time at which each service is needed, and the amount, frequency, duration and scope of each service, and to ensure adherence to the established schedule;

2.9.6.12.3.7 The ability to provide immediate (i.e., "real time") notification to care coordinators if a provider or worker does not arrive as scheduled or otherwise deviates from the authorized schedule so that service gaps and the reason the service was not provided as scheduled, are immediately identified and addressed, including through the implementation of back-up plans, as appropriate;

2.9.6.12.3.8 The ability for a provider of home-delivered meals to log in and enter the meals that have been delivered during the day, including the member's name, time delivered and the reason a meal was not delivered (when applicable);

2.9.6.12.3.9 The ability for a provider, e.g., adult day care provider, to log in and enter attendance for the day;

2.9.6.12.3.10 The ability for the provider/worker to submit claims to the CONTRACTOR (claims from workers shall be submitted initially to the FEA, and the FEA shall provide claims information to the CONTRACTOR as specified in the subcontract with the FEA; see Section 2.26); and

2.9.6.12.3.11 The ability to reconcile paid claims with service authorizations.

2.9.6.12.4 The CONTRACTOR shall not require that provider staff delivering home-delivered meals log in at arrival and departure. Instead, the provider may opt to log in on a daily basis after meals have been delivered and enter information on all the meals that were delivered that day (see Section 2.9.6.12.3.8 above).

2.9.6.12.5 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services are provided as specified in the plan of care, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider/worker; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a member is receiving services, including after the CONTRACTOR's regular business hours.

2.9.6.12.6 The CONTRACTOR shall develop and maintain an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols, including but not limited to the following:

2.9.6.12.6.1 The ability to capture and track key dates and timeframes specified in this Agreement, e.g., as applicable, date of referral for potential CHOICES enrollment, date the level of care assessment and plan of care were submitted to TENNCARE, date of CHOICES enrollment, date of development of the plan of care, date of authorization of the plan of care, date of initial service delivery for each service in the plan of care, date of each level of care and needs reassessment, date of each update to the plan of care, and dates regarding transition from a nursing facility to the community;

2.9.6.12.6.2 The ability to capture and track compliance with minimum care coordination contacts as specified in Section 2.9.6.9.4 of this Agreement;

2.9.6.12.6.3 The ability to notify the care coordinator about key dates, e.g., TennCare eligibility end date, date for annual level of care reassessment, date of needs reassessment, and date for update to the plan of care;

2.9.6.12.6.4 The ability to capture and track eligibility/enrollment information, level of care assessments and reassessments, and needs assessments and reassessments;

2.9.6.12.6.5 The ability to capture and monitor the plan of care;

2.9.6.12.6.6 The ability to track requested and approved service authorizations, including covered long-term care services and any services provided as a cost-effective alternative to other covered services;

2.9.6.12.6.7 The ability to document all referrals received by the care coordinator on behalf of the member for covered long-term care services; home health and private duty nursing services; other physical or behavioral health services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and other social support services and assistance needed in order to ensure the member's health, safety and welfare,

and as applicable, to delay or prevent the need for more expensive institutional placement, including notes regarding how such referral was handled by the care coordinator;

2.9.6.12.6.8 The ability to establish a schedule of services for each member which identifies the time at which each service is needed and the amount, frequency, duration and scope of each service;

2.9.6.12.6.9 The ability to provide, via electronic interface with the electronic visit verification system, service authorizations on behalf of a CHOICES member, including the schedule at which each service is needed;

2.9.6.12.6.10 The ability to provide, via electronic interface with the FEA, referrals and service authorizations;

2.9.6.12.6.11 The ability to track service delivery against authorized services and providers;

2.9.6.12.6.12 The ability to track actions taken by the care coordinator to immediately address service gaps; and

2.9.6.12.6.13 The ability to document case notes relevant to the provision of care coordination.

2.9.7 **Consumer Direction of HCBS**

2.9.7.1 General

2.9.7.1.1 The CONTRACTOR shall offer consumer direction of HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, homemaker, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons electing consumer direction of HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible HCBS or to withdraw from participation in consumer direction of HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE shall establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of HCBS.

2.9.7.1.2 Consumer direction is a process by which eligible HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Care rather than the TennCare Solutions Units, which manages medical appeals pertaining to TennCare benefits (i.e., services).

2.9.7.1.3 Members who participate in consumer direction of HCBS choose either to serve as the employer of record of their workers or to designate a representative (see definition below in Section 2.9.7.2.1) to serve as the employer of record on his/her behalf. As the employer of record the member or his/her representative is responsible for the following:

2.9.7.1.3.1 Hiring/Firing workers;

2.9.7.1.3.2 Determining workers' duties and developing job descriptions;

2.9.7.1.3.3 Scheduling workers;

2.9.7.1.3.4 Supervising workers;

2.9.7.1.3.5 Evaluating worker performance and addressing any identified deficiencies or concerns;

2.9.7.1.3.6 Setting wages up to a specified maximum amount established by TENNCARE;

2.9.7.1.3.7 Training workers to provide personalized care based on the member's needs and preferences;

2.9.7.1.3.8 Reviewing and approving timesheets;

2.9.7.1.3.9 Reviewing and ensuring proper documentation for services provided; and

2.9.7.1.3.10 Developing and activating as needed a back-up plan to address instances when a scheduled worker does not show up.

2.9.7.1.3.10.1 The back-up plan developed by the member may include both paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up staff who are willing and available to serve in this capacity for consumer directed services. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction. The member must make arrangements for the provision of needed medical care and does not have the option of going without needed services.

2.9.7.1.3.10.2 In some respects, the back-up plan for consumer direction is similar to the back-up plan that contract providers are obligated to maintain (i.e., to address instances where an agency staff person does not show up). As the employer of record, the

member and/or representative have willingly taken on the responsibilities that would otherwise be performed by the contract provider agency. However, the back-up plan for consumer directed workers is more comprehensive in that it is intended to facilitate the provision of needed care even when another paid worker is not available and is thus comparable to and shall be integrated with the back-up plan which is part of the member's plan of care and which also addresses (as applicable) instances in which a contract provider is authorized to provide care and the contract provider's back-up plan fails. The CONTRACTOR shall assess the adequacy of the back-up plan.

2.9.7.2 Representative

2.9.7.2.1 A member may designate, or have appointed by a guardian, a representative to assume the consumer direction responsibilities on his/her behalf. A representative shall meet, at minimum the following requirements: be at least 18 years of age, have a personal relationship with the member and understand his/her support needs; know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

2.9.7.2.2 In order to participate in consumer direction of HCBS with the assistance of a representative, one of the following must apply: (1) the member must have the ability to designate a person to serve as his/her representative or (2) the member has a legally appointed representative who may serve as the member's representative.

2.9.7.2.3 The care coordinator shall determine if the member requires assistance in carrying out the responsibilities required for consumer direction and therefore requires a representative. The member's care coordinator/care coordination team shall verify that a representative meets the qualifications as described in Section 2.9.7.2.1 above.

2.9.7.2.4 A member's representative shall not receive payment for serving in this capacity and shall not serve as the member's worker for any consumer directed service. The CONTRACTOR shall use a representative agreement developed by TENNCARE to document a member's choice of a representative for consumer direction of HCBS and the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. Ongoing, the fiscal employer agent (FEA) shall notify the CONTRACTOR within one (1) business day when it becomes aware of any changes to a representative's contact information. Conversely, the CONTRACTOR shall notify the FEA within one (1) business day when it becomes aware of any changes to a representative's contact information.

2.9.7.2.5 The representative agreement shall be signed by the member (or person authorized to sign on member's behalf which shall not also be the representative for consumer direction) and the representative in the presence of the care coordinator. The care coordinator shall include the representative agreement in the member's file and provide copies to the member and/or the member's representative and the FEA (see Section 2.9.7.3 below).

2.9.7.2.6 A member may change his/her representative at any time. To the extent possible, the member shall notify his/her care coordinator ten (10) days in advance of initiating a change in representatives. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to a new representative. TENNCARE shall establish reasonable limitations on the frequency with which members may change representatives. In the event a member's representative is unexpectedly no longer willing or able to fulfill the consumer direction functions on behalf of the member, the CONTRACTOR shall, as soon as possible, work with the member to find an alternate representative.

2.9.7.2.7 The member's care coordinator/care coordination team shall verify that the new representative meets the qualifications as described in Section 2.9.7.2.1 above. A new representative agreement shall be completed and signed, in the presence of a care coordinator, prior to the new representative assuming the respective responsibilities. The member's care coordinator/care coordination team shall immediately notify the FEA when a member changes his/her representative and provide a copy of the representative agreement. The CONTRACTOR shall facilitate a seamless transition to the new representative, and ensure that there are no interruptions or gaps in services. As part of the needs assessment and plan of care process, the care coordinator shall educate the member about the importance of notifying the care coordinator prior to changing a representative.

2.9.7.2.8 The FEA shall ensure that the new representative signs all service agreements (see Section 2.9.7.6.6).

2.9.7.3 <u>Fiscal Employer Agent (FEA)</u>

2.9.7.3.1 The CONTRACTOR shall enter into a subcontract with the FEA specified by TENNCARE to provide assistance to members choosing consumer direction.

2.9.7.3.2 The FEA shall fulfill, at a minimum, the following financial administrative and supports broker functions for all CHOICES members electing consumer direction of HCBS:

2.9.7.3.2.1 Assign a supports broker to each CHOICES member electing to participate in consumer direction of HCBS;

2.9.7.3.2.2 Assist in identifying and addressing in the risk assessment and planning processes any additional risk associated with receiving consumer directed services;

2.9.7.3.2.3 Provide initial and ongoing training to members and their representatives (as applicable) on consumer direction and other relevant issues (see Section 2.9.7.7 of this Agreement);

2.9.7.3.2.4 Verify worker qualifications, including, as specified by TENNCARE, conduct background checks on workers, enroll workers into Medicaid, assign provider Medicaid ID numbers, and hold Medicaid provider agreements (see Section 2.9.7.6.1 of this Agreement);

2.9.7.3.2.5 Provide initial and ongoing training to workers on consumer direction and other relevant issues (see Section 2.9.7.7 of this Agreement);

2.9.7.3.2.6 Assist the member and/or representative in developing and updating service agreements (see Section 2.9.7.6.6);

2.9.7.3.2.7 Receive, review and process timesheets;

2.9.7.3.2.8 Resolve timesheet discrepancies;

2.9.7.3.2.9 Obtain documentation from the member and/or representative to ensure that services were provided prior to payment of timesheets;

2.9.7.3.2.10 Withhold, file and pay applicable: federal, state and local income taxes; employment and unemployment taxes; and worker's compensation;

2.9.7.3.2.11 Pay workers for services rendered;

2.9.7.3.2.12 Facilitate resolution of any disputes regarding payment to workers for services rendered;

2.9.7.3.2.13 Monitor quality of services provided by workers; and

2.9.7.3.2.14 Report to the CONTRACTOR on worker and/or staff identification of, response to, participation in and/or investigation of critical incidents (see Section 2.15.8).

2.9.7.3.3 The FEA shall also fulfill, at a minimum, the following financial administrative and supports broker functions for CHOICES members electing consumer direction of HCBS on an as needed basis:

2.9.7.3.3.1 Assist the member and/or representative in developing job descriptions;

2.9.7.3.3.2 Assist the member and/or representative in locating and recruiting workers;

2.9.7.3.3.3 Assist the member and/or representative in interviewing workers (developing questions, evaluating responses);

2.9.7.3.3.4 Assist the member and/or representative in scheduling workers;

2.9.7.3.3.5 Assist the member and/or representative in managing and monitoring payments to workers; and

2.9.7.3.3.6 Assist the member and/or representative in monitoring and evaluating the performance of workers.

2.9.7.3.4 The CONTRACTOR's care coordination functions shall not duplicate the supports broker functions performed by the FEA or its subcontractor. A member's care coordinator shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction.

2.9.7.3.5 The CONTRACTOR's subcontract with the FEA shall include the provisions specified by TENNCARE in the model FEA subcontract. The subcontract shall specify at a minimum the functions noted in Section 2.9.7.3.2 through 2.9.7.3.3. above (or a reference to the functions); the FEA's responsibilities for communicating with the CONTRACTOR, members and workers; customer service requirements; processes and timeframes for authorizations of consumer directed services; processes and timeframes for service initiation; requirements and timeframes for processing employee payroll; process and requirements for billing; systems requirements and information exchange requirements; requirements for notifying MCO regarding readiness to initiate consumer direction of HCBS for a member; role and responsibility for training staff, contractors, members, representatives and workers regarding abuse and neglect plan protocols as described in Section 2.24.4.3 of this Agreement; and role and responsibility for critical incident reporting and management (see Section 2.15.8.4.6 of this Agreement).

2.9.7.3.6 The CONTRACTOR in collaboration with the FEA shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.

2.9.7.3.7 The CONTRACTOR and FEA shall develop a protocol for interfaces and transfers of customer service inquiries per the requirements of Section 2.18 of this Agreement.

2.9.7.3.8 The CONTRACTOR shall provide to the FEA copies of all relevant initial and updated member documents, including at a minimum, plans of care, representative agreements and risk agreements. The CONTRACTOR shall provide to the FEA all relevant documentation prior to service delivery.

2.9.7.4 <u>Needs Assessment/Plan of Care Process</u>

2.9.7.4.1 A CHOICES member may choose to direct needed eligible HCBS at anytime: during CHOICES intake, through the needs assessment/reassessment and plan of care and plan of care update processes; and outside of these processes. The care coordinator shall assess the member's needs for eligible HCBS per requirements in Sections 2.9.6.2.4, 2.9.6.3 and 2.9.6.5, as applicable. The care coordinator shall use the plan of care process (including updates) to identify the eligible services that the member will direct and to facilitate the member's enrollment in consumer direction of HCBS.

2.9.7.4.2 The CONTRACTOR shall obtain written confirmation of the member's decision to participate in consumer direction of HCBS.

2.9.7.4.2.1 The care coordinator shall assist the member in identifying which of the needed eligible HCBS shall be consumer directed, provided by contract providers or a combination of both, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.3 If the member intends to direct one or more needed eligible HCBS, throughout the period of time that consumer direction is being initiated, the CONTRACTOR shall arrange for the provision of needed HCBS through contract providers in accordance

with 2.9.6. The care coordinator shall obtain from the member his/her choice of contract providers who will provide HCBS until such time as workers are secured and ready to begin delivering care through consumer direction,.

2.9.7.4.3.1 If a member has been assessed to need companion care services, the CONTRACTOR shall identify non-residential services that will offer interim support to address the member's needs and assist the member in obtaining contract providers for these services.

2.9.7.4.4 The CONTRACTOR shall be responsible for providing all needed eligible HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf (see Section 2.9.7.6.1 of this Agreement). If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of HCBS, based upon the results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member's file.

2.9.7.4.5.1 If, based on the results of the self-assessment, the care coordinator determines that a member requires assistance to direct his/her services, and the member has not already designated a representative to assume the consumer direction functions, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf.

2.9.7.4.5.2 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to deny participation in consumer direction because a care coordinator has determined that the health, safety and welfare of the member would be in jeopardy if the member participates in consumer direction without a representative but the member does not want to appoint a representative to assist in directing his/her services. The CONTRACTOR shall abide by TENNCARE's decision.

2.9.7.4.6 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1 of this Agreement) and that a representative agreement is completed and signed by the member and the person prior to forwarding a referral to the FEA (see Section 2.9.7.4.7 below).

2.9.7.4.7 Within two (2) business days of signing the representative agreement, the CONTRACTOR shall forward to the FEA a referral initiating the member's

participation in consumer direction of HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, social security number; the name of the representative and telephone number, if applicable, (if known at the time) and social security number; member TennCare ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each; and care coordinator name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of HCBS.

2.9.7.4.8 Within two (2) business days of receipt of the referral, the FEA shall assign a supports broker to the member and shall notify the care coordinator of the assignment.

2.9.7.4.9 Within five (5) days of receipt of the referral, the FEA shall contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating consumer direction of HCBS.

2.9.7.4.10 The care coordinator, in conjunction with the FEA, shall assist the member and/or the representative as needed in developing a back-up plan for consumer direction that adequately identifies how the member will address situations when a scheduled worker fails to show up. The member and his/her representative (as applicable) shall have primary responsibility for the development of the back-up plan for consumer directed services. The back-up plan shall include the names and telephone numbers of contacts for alternate care, the order in which contact shall be made and the services to be provided by contacts. Back-up workers may include paid and non-paid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up staff who are willing and available to serve in this capacity. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction. All persons and/or organizations noted in back-up plan for consumer directed services shall first be contacted by the member and/or representative to determine their willingness and availability to serve as back-up workers. The care coordinator shall follow-up with these persons and/or organizations to confirm their willingness and availability to provide care when needed. The CONTRACTOR shall give a copy of the back-up plan, and any updates, to the FEA.

2.9.7.4.11 The care coordinator, with assistance from the FEA, shall assist the member and/or the representative in reviewing and updating the risk agreement (as prescribed in Section 2.9.6.9.2.1.10 of this Agreement) in order to ensure that any additional risks associated with the member's decision to direct his/her services are taken into consideration and that additional measures to mitigate these risks are identified. The representative (if applicable) shall participate in the process. The updated risk agreement shall be signed by the care coordinator and the member (or the member's representative). A copy of the risk agreement shall be given to the member or the member's representative and the FEA. The FEA and care coordinator shall file a copy of the updated risk assessment in the member's files.

2.9.7.4.12 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the member's supports broker is invited to participate in these meetings.

2.9.7.5 Authorizations for Consumer Directed Services and Service Initiation

2.9.7.5.1 Consumer direction of HCBS shall not be initiated until all requirements are fulfilled including but not limited to the following: (1) the FEA verifies that the member's employer and related documentation is in order; (2) the FEA verifies that workers meet all qualifications, including participation in required training; (3) there is a signed service agreement specific to each individual worker (see Section 2.9.7.6.7 of this Agreement); and (4) the CONTRACTOR issues to the FEA an authorization for consumer directed services (see 2.9.7.5.6 below) for each service.

2.9.7.5.2 The FEA shall work with the member to determine the appropriate level of assistance necessary to recruit, interview and hire workers and provide the assistance.

2.9.7.5.3 Once potential workers are identified, the FEA shall verify that a potential worker meets all applicable qualifications (see Section 2.9.7.6.1 of this Agreement).

2.9.7.5.4 The FEA shall ensure that a service agreement is signed between the member or member's representative and his/her worker within five (5) business days following the FEA's verification that a worker meets all qualifications.

2.9.7.5.5 Within ten (10) days of receipt of the referral and every ten (10) days thereafter, the FEA shall update the care coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining workers for each identified consumer directed service and anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

2.9.7.5.6 The provision of consumer directed services shall begin as soon as possible but no longer than sixty (60) days from the date of the CONTRACTOR's referral to the FEA. Prior to beginning the provision of consumer directed services, the FEA shall notify the CONTRACTOR that all requirements have been fulfilled, and the date that consumer directed services can begin. Within two (2) business days of receipt of the notification from the FEA, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services. Each authorization for consumer directed services shall include the required elements for a referral (see Section 2.9.7.4.7 of this Agreement) including: authorized service, authorized units of service, including amount, frequency and duration, start and end dates, and service code.

2.9.7.5.7 If initiation of consumer directed services does not begin within sixty (60) days from the date of the CONTRACTOR's referral to the FEA, the FEA shall contact the CONTRACTOR regarding the cause of the delay. The CONTRACTOR shall determine the appropriate next steps, including but not limited to whether an extension is warranted or if the member is still interested in participating in consumer direction of HCBS.

2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall contact the FEA who will be responsible for assisting the member or his/her representative as needed in activating the member's back-up plan for consumer direction.

2.9.7.5.9 Within five (5) business days of the scheduled start date of consumer directed services as specified in the authorization of consumer directed services a member of the care coordinator team shall contact the member or his/her representative to confirm that services are being provided and that the member's needs are being met.

2.9.7.5.10 On an ongoing basis, in addition to requirements specified above in 2.9.7.5.3 – 2.9.7.5.7 above:

2.9.7.5.10.1 The CONTRACTOR shall develop and forward to the FEA a new authorization for consumer directed services when the following occur: a change in the number of service units, or the frequency or duration of service delivery; or a change in the services to be provided through consumer direction, including the provision of a new service through consumer direction or termination of a service through consumer direction.

2.9.7.6 Worker Qualifications

2.9.7.6.1 The FEA shall ensure that workers meet all requirements prior to the worker providing services. The FEA shall ensure that workers: meet all TennCare established requirements for providers of comparable, non-consumer directed services; pass a background check which includes criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company, verification that the person's name does not appear on the State abuse registry, verification that the person's name does not appear on the state and national sexual offender registries and licensure verification, as applicable; complete all required training, including the training specified in Section 2.9.7.7 of this Agreement; complete all required applications to become a TennCare provider; sign the TennCare provider agreement; and are assigned a Medicaid provider ID number.

2.9.7.6.1.1 A member cannot waive a background check for a potential worker. The following findings shall disqualify a person from serving as a worker:

2.9.7.6.1.1.1 Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug;

2.9.7.6.1.1.2 Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held;

2.9.7.6.1.1.3 Identification on the abuse registry;

2.9.7.6.1.1.4 Identification on the state or national sexual offender registry;

2.9.7.6.1.1.5 Failure to have a required license; and

2.9.7.6.1.1.6 Refusal to cooperate with a background check.

2.9.7.6.1.2 In certain instances a member may choose to hire a worker that fails a background check. Exceptions to disqualification may be granted at the member's discretion and only if all of the following conditions are met:

2.9.7.6.1.2.1 Offense is a misdemeanor;

2.9.7.6.1.2.2 Offense occurred more than five (5) years ago;

2.9.7.6.1.2.3 Offense is not related to physical or sexual or emotional abuse of another person;

2.9.7.6.1.2.4 Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and

2.9.7.6.1.2.5 There is only one disqualifying offense.

2.9.7.6.2 The FEA shall make the decision regarding exceptions to disqualification. In the event a member chooses to hire a worker that has failed a background check but has met all of the conditions for an exception to disqualification and the FEA has granted the exception, the FEA shall notify the care coordinator prior to initiation of services provided by that worker.

2.9.7.6.3 Workers are not required to be contract providers. The CONTRACTOR shall not require a worker to sign a provider agreement or any other agreement not specified by TENNCARE.

2.9.7.6.4 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as a worker, such as a neighbor or a friend.

2.9.7.6.5 Members may hire family members, excluding spouses, to serve as a worker. A family member shall not be reimbursed for a service that he/she would have otherwise provided without pay. The CONTRACTOR shall use the needs assessment process (Section 2.9.6.5) to assess the member's available existing supports, including supports provided by family members.

2.9.7.6.6 A member may have multiple workers or both a worker and a contract provider for a given service, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. A member may elect to have a worker provide more than one service.

2.9.7.6.7 A member shall develop a service agreement with each worker. The service agreement template shall be developed by TENNCARE and shall include, at a minimum: the roles and responsibilities of the worker and the member; the worker's schedule (as developed by the member and/or representative), including hours and days; the scope of each service, i.e., the specific tasks and functions the worker is to perform; the service rate; and the requested start date for services. The service agreement shall serve as the worker's written confirmation of his/her commitment to initiate services on or before the date specified and to provide services in accordance with specified terms (including the tasks and functions to be performed and the schedule at which care is needed). If necessary, the FEA shall assist in this process. Service agreements shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Service agreements shall be signed by the new representative when there is a change in representatives.

2.9.7.6.8 The service agreement shall also stipulate if a worker will provide one or more self-directed health care tasks, the specific task(s) to be performed, and the frequency of each self-directed health care task (see Section 2.7 3).

2.9.7.6.9 The FEA shall ensure that a service agreement is in place for each worker prior to the worker providing services.

2.9.7.6.10 A copy of each service agreement shall be provided to the member and/or representative. The FEA shall give a copy of the service agreement to the worker and shall maintain a copy for its files.

2.9.7.6.11 A member may terminate a worker at any time if he/she feels that the worker is not adhering to the terms of the service agreement and/or is not providing quality services. If the FEA or care coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the plan of care, but the member and/or representative chooses to continue to employ the worker, the care coordinator shall note the concern and the member's choice to continue using the worker in the member's plan of care, and shall update the risk assessment and/or risk agreement as needed. The FEA and care coordinator shall collaborate to develop strategies to address identified issues and concerns. The FEA shall inform the member and/or representative of any potential risks associated with continuing to use the worker. The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll the member from consumer direction because a care coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker. The CONTRACTOR and FEA shall abide by TENNCARE's decision.

2.9.7.6.12 A member shall have the flexibility to choose from a range of TENNCARE specified reimbursement levels for all eligible consumer directed HCBS, excluding companion care services which shall be reimbursed at the rate specified by TENNCARE.

2.9.7.6.13 In order to receive payment for services rendered, all workers must:

2.9.7.6.13.1 Submit to the member and the FEA planned work schedules two weeks in advance and when billing. The FEA shall input schedules into the EVV; and

2.9.7.6.13.2 Maintain and submit timesheets and documentation of service delivery (i.e., documentation of the tasks and functions performed during the provision of services), and any other documentation, as required, for units of service delivered; and

2.9.7.6.13.3 Provide no more than forty (40) hours of services within a consecutive seven (7) day period, with the following exceptions:

2.9.7.6.13.3.1 The worker provides companion care services; or

2.9.7.6.13.3.2 The worker serves as a back-up worker during this period, in which case payment shall be at the established rate, with no overtime pay, in accordance with applicable labor law. The FEA shall monitor the frequency of instances in which a worker provides more than forty (40) hours of service within a consecutive seven day period for this reason, and shall work with the member and/or representative to develop an adequate supply of reliable workers.

2.9.7.6.13.4 The FEA shall enter worker schedules into the EVV, but may delegate this responsibility to the member and/or representative when appropriate.

2.9.7.7 Training

2.9.7.7.1 The CONTRACTOR shall require all members electing to enroll in consumer direction of HCBS and/or their representatives to receive relevant training prior to service initiation. The FEA shall be responsible for providing or arranging for the training. When training is not directly provided by the FEA, the FEA shall validate completion of training.

2.9.7.7.2 At a minimum, consumer direction training for members and/or representatives shall address the following issues:

2.9.7.7.2.1 Understanding the role of members and representatives in consumer direction;

2.9.7.7.2.2 Understanding the role of the care coordinator and the FEA;

2.9.7.7.2.3 Selecting workers;

2.9.7.7.2.4 Abuse and neglect identification and reporting;

2.9.7.7.2.5 Being an employer, evaluating worker performance and managing employees;

2.9.7.7.2.6 Fraud and abuse;

2.9.7.7.2.7 Performing administrative tasks such as reviewing and approving time sheets; and

2.9.7.7.2.8 Scheduling workers and back-up planning.

2.9.7.7.3 Ongoing training shall be provided by the FEA to members and/or representatives upon request and/or if a care coordinator or FEA, through monitoring, determines that additional training is warranted.

2.9.7.7.4 The FEA shall be responsible for providing or arranging for the training of all workers prior to service initiation. When training is not directly provided by the FEA, the FEA shall validate completion of training. At a minimum, training shall consist of the following required elements:

2.9.7.7.4.1 Overview of the CHOICES program and consumer direction of HCBS;

2.9.7.7.4.2 Caring for elderly and disabled populations;

2.9.7.7.4.3 Abuse and neglect identification and reporting;

2.9.7.7.4.4 CPR and first aid certification;

2.9.7.7.4.5 Critical incident reporting;

2.9.7.7.4.6 Submission of timesheets, required documentation and withholdings;

2.9.7.7.4.7 EVV system functionality, requirements and how to use; and

2.9.7.7.4.8 As appropriate, administration of self-directed health care task(s).

2.9.7.7.5 The member or representative, with assistance of the FEA, shall determine to what extent the member or representative shall be involved in the above-specified training, except that the member or representative must direct training regarding the administration of self-directed health care tasks.

2.9.7.7.6 In addition to the training noted above in 2.9.7.7.4.1 – 2.9.7.7.4.8, the member shall provide training to the worker regarding individualized service needs and preference.

2.9.7.7.7 The FEA shall verify that workers have successfully completed all required training prior to service initiation and payment for services.

2.9.7.7.8 Ongoing, the FEA shall ensure that workers maintain CPR and first aid certification and receive required refresher training as a condition of continued employment and shall arrange for the appropriate training. Additional training components may be provided to a worker to address issues identified by the FEA, care coordinator, member and/or the representative or at the request of the worker.

2.9.7.7.9 Refresher training may be provided more frequently if determined necessary by the FEA, care coordinator, member and/or representative or at the request of the worker.

2.9.7.8 <u>Monitoring</u>

2.9.7.8.1 The FEA shall conduct semi-annual face-to-face visits in the member's place of residence and conduct monthly phone contacts. These visits and contacts shall supplement and not supplant the minimum care coordinator contacts. The FEA shall use these visits to monitor the quality of service delivery including:

2.9.7.8.1.1 Identifying any service delivery issues;

2.9.7.8.1.2 Determining the adequacy and appropriateness of documentation of service delivery; and

2.9.7.8.1.3 Determining the efficacy of back-up plans and processes.

2.9.7.8.2 At a minimum, the FEA shall conduct the following additional monitoring activities:

2.9.7.8.2.1 Quarterly reviews of expenditures for each member; and

2.9.7.8.2.2 Monthly reviews of hours billed for services across all members, by each worker.

2.9.7.8.3 The CONTRACTOR shall monitor a member's participation in consumer direction of HCBS to determine, at a minimum, the success and the viability of the service delivery model for the member. The CONTRACTOR shall note any patterns, such as frequent turnover of representatives and changing between consumer direction of HCBS and contract providers that may warrant intervention by the CONTRACTOR. The CONTRACTOR may submit a request to TENNCARE, pursuant to TennCare policy, to involuntarily withdraw the member from consumer direction of HCBS if the CONTRACTOR has concerns about its ability to protect the health, safety and welfare of the member (see Section 2.9.7.8.5).

2.9.7.8.4 If at any time the care coordinator or FEA suspects abuse or neglect on the part of the representative or worker, the care coordinator and/or FEA shall report the allegations to the CONTRACTOR. The CONTRACTOR shall report the representative and/or worker to APS. The representative and/or worker shall immediately be released from his/her duties until the APS investigation is complete. The care coordinator shall work with the member to find a new representative, and the FEA shall work with the member to find a suitable replacement worker. If the allegations are substantiated as a result of the APS investigation, the representative and/or worker shall no longer be allowed to participate in the CHOICES program in any capacity.

2.9.7.8.5 In the event the CONTRACTOR believes that it cannot safely and effectively serve the member in the community, the care coordinator, with the assistance of and input from the FEA, shall review with the member the previously developed risk agreement and update it to ensure that any additional identified risks are incorporated and measures are identified to mitigate risks. The representative (if applicable) shall participate in the process. The updated risk assessment shall be signed by the member or representative and the care coordinator. A copy shall be given to the member or representative. The member's care coordinator/care coordination team and the FEA shall file a copy in the member's files. If the CONTRACTOR does not believe the member can be safely and effectively served in the community directing his/her services, the CONTRACTOR may request to involuntarily withdraw the member from consumer direction of HCBS, pursuant to TennCare policy (see Section 2.9.7.9 below).

2.9.7.9 Withdrawal from Consumer Direction of HCBS

2.9.7.9.1 A member may voluntarily withdraw from consumer direction of HCBS at any time. The member and/or representative shall notify the care coordinator as soon as he/she determines that he/she is no longer interested in participating in consumer direction of HCBS.

2.9.7.9.2 Upon receipt of a member's request to withdraw from consumer direction of HCBS, the CONTRACTOR shall conduct a face-to-face visit and update the member's plan of care, as appropriate, to initiate the process to transition the member to contract providers.

2.9.7.9.3 The CONTRACTOR may initiate involuntary withdrawal of a member from consumer direction of HCBS:

2.9.7.9.3.1 If a member's representative fails to perform in accordance with the terms of the representative agreement and the health, safety and welfare of the member is at risk, and the member wants to continue to use the representative.

2.9.7.9.3.2 If a member has consistently demonstrated that he/she is unable to manage, with sufficient supports (including appointment of a representative) his/her services and the care coordinator or FEA has identified health, safety and/or welfare issues.

2.9.7.9.3.3 A care coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker.

2.9.7.9.3.4 Other significant concerns regarding the member's participation in consumer direction which jeopardize the health, safety or welfare of the member.

2.9.7.9.4 The CONTRACTOR shall forward to TENNCARE, pursuant to TennCare policy, a request to involuntarily withdraw a member from consumer direction of HCBS. The request shall include the reasons for withdrawing the member and the measures taken by the CONTRACTOR and/or the FEA to address identified issues.

2.9.7.9.5 If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations, and the member shall have the right to appeal the determination (see Section 2.19.3.12of this Agreement). Upon notification or the resolution of a timely filed appeal, the CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition from workers to contract providers, with no interruptions or gaps in services.

2.9.7.9.6 Voluntary or involuntary withdrawal of a member from consumer direction of HCBS shall not affect a member's eligibility for long-term care services or enrollment in CHOICES.

2.9.7.9.7 Members who have been involuntarily withdrawn may request to be reinstated in consumer direction of HCBS. The care coordinator shall work with the FEA to ensure that the issues previously identified as reasons for withdrawal have been adequately addressed prior to reinstatement. All members shall be required to

participate in consumer direction training programs prior to re-instatement in consumer direction of HCBS.

2.9.8 **Coordination and Collaboration for Members with Behavioral Health Needs**

2.9.8.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health, behavioral health, and long-term care services. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term care services and ensuring collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical health, behavioral health, and long-term care providers, exchange of information, confidentiality, assessment, treatment plan and plan of care development and implementation, collaboration, MCO case management, care coordination (for CHOICES members) and disease management, provider training, and monitoring implementation and outcomes.

2.9.8.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding, at a minimum, the items identified in Section 2.9.8.2 as well as prior authorization, claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section 2.26 of this Agreement.

2.9.8.3 Screening for Behavioral Health Needs

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

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

2.9.8.3.3 As part of the care coordination process (see Section 2.9.6), the CONTRACTOR shall ensure that behavioral health needs of CHOICES members are identified and addressed.

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 members with SED/SPMI are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health 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.

2.9.8.5 Referrals to PCPs

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

2.9.8.6 Referrals to CHOICES

The CONTRACTOR shall ensure that members with both long-term care and behavioral health needs are referred to the CONTRACTOR for CHOICES intake (see Section 2.9.6.3). The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need long-term care services to the CONTRACTOR.

2.9.8.7 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services. For CHOICES members in Groups 2 and 3 with behavioral health needs, the member's care coordinator shall encourage participation of the member's behavioral health provider in the care planning process and shall incorporate relevant information from the member's behavioral health treatment plan (see Section 2.7.2.1.4) in the member's plan of care (see Section 2.9.6.6).

2.9.8.8 MCO Case Management, Disease Management, and CHOICES Care Coordination

The CONTRACTOR shall use its MCO case management, disease management, and CHOICES care coordination programs (see Sections 2.9.5, 2.8, and 2.9.6) to support

the continuity and coordination of covered physical health, behavioral health, and long-term care services and the collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on disease management stratification (see Section 2.8.3), to be enrolled in both a disease management program and MCO case management. For CHOICES members, MCO case management and/or disease management activities shall be integrated with the care coordination process (see Sections 2.9.5.4, and 2.9.6.1.8).

2.9.8.9 Monitoring

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

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

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

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

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

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

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

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

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

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

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

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

2.9.9.3.3 An evaluation shall be performed prior to discharge to determine if mental health case management services are medically necessary. Once deemed medically necessary, the mental health case manager shall be involved in discharge planning; if there is no mental health case manager, then the outpatient provider shall be involved; and

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

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

2.9.9.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section 2.9.9.3.2.

2.9.10 **Coordination of Pharmacy Services**

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

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

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

2.9.10.3.1 Analyzing prescription drug data and/or reports provided by the PBM or TENNCARE to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to MCO case management and/or disease management programs and/or refer them to CHOICES intake (see Section 2.9.6) as appropriate; if a CHOICES member is identified as a high-utilizer or as inappropriately using pharmacy services, relevant prescription drug data and/or reports for the member shall be provided to the member's care coordinator, and the care coordinator shall take appropriate next steps, which may include coordination with the member's PCP;

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

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

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

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

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

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

2.9.11 **Coordination of Dental Benefits**

2.9.11.1 General

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

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

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

2.9.11.2 Services and Responsibilities

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

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

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

2.9.11.2.3 Maintenance of confidentiality;

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

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

2.9.11.3 Operating Principles

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

2.9.11.4 Resolution of Requests for Prior Authorization

2.9.11.4.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare enrollee. The CONTRACTOR shall require that its DBM care coordinators will, in addition to their responsibilities for DBM care coordination, deal with issues related to requests for prior authorization that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM with a list of its DBM care coordinators and telephone number(s) at which each DBM care coordinator may be contacted. When the CONTRACTOR receives a request for prior authorization from a provider for a member and the CONTRACTOR believes the service is the

responsibility of the DBM, the CONTRACTOR's DBM care coordinator shall contact the DBM's care coordinator by the next business day after receiving the request for prior authorization. The DBM care coordinator shall also contact the member and/or member's provider. For routine requests contact to the member or member's provider shall be made within fourteen (14) days or less of the provider's request for prior authorization and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations. For urgent requests, contact shall be made immediately after receiving the request for prior authorization.

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

2.9.11.5 Claim Resolution Processes

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

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

2.9.11.5.3 The CONTRACTOR shall assign claims coordinators and other representatives, as needed, to a joint CONTRACTOR/DBM Claims Coordination Committee. The number of members serving on the Claims Coordination Committee shall be determined within ten (10) calendar days of the execution of this Agreement by the mutual agreement of the DBM and MCO. The CONTRACTOR shall, at a minimum, assign two (2) representatives to the committee. The make-up of the committee may

be revisited from time to time during the term of this Agreement. The Claims Coordination Committee shall review any disputes and negotiate responsibility between the CONTRACTOR and the DBM. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party shall reimburse and abide by the prior decisions of that party. Reimbursement shall be made within ten (10) calendar days of the Claims Coordination Committee's decision.

2.9.11.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to both the CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s) as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.

2.9.11.5.5 If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days of the meeting, submit a Request for Resolution of the dispute to the State or the State's designee for a decision on responsibility.

2.9.11.5.6 The process before the submission of a Request for Resolution, as described above, shall be completed within thirty (30) calendar days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) calendar days of receiving the claim for payment, the MCO and the DBM shall be responsible for enforcing hold harmless protections for the member and the party who first received the request or claim from the provider shall be responsible for authorization and payment to the provider in accordance with the requirements of the MCO's or DBM's respective Agreement/contract with the State of Tennessee. Moreover, the party that first received the request or claim from the provider shall also make written request of all requisite documentation for payment and shall provide written reasons for any denial.

2.9.11.5.7 The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable Agreement/contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution.

2.9.11.5.8 The State or its designee shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information ("Decision"). The Decision may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The Decision shall be determined solely by the State or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments

made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars ($1,000), for each Request for Resolution. The amount of the DBM's or MCO's payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party's payment responsibility as described in this Section, Section 2.9.11.5.8, within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

2.9.11.6 Denial, Delay, Reduction, Termination or Suspension

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

2.9.11.7 Emergencies

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

2.9.11.8 Claims Processing Requirements

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

2.9.11.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq*. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section 2.9.11.9

2.9.11.10 Duties and Obligations

The existence of any dispute under this Agreement shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective obligations, including their obligations established in their respective Agreements/contracts with the State pending resolution of the dispute under this Section, Section 2.9.11.10. In accordance with TCA 56-32-126(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.11.11 Confidentiality

2.9.11.11.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, to cooperate with the State to develop confidentiality guidelines that (1) meet state, federal, and other regulatory

requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards shall apply to both DBM's and MCO's providers and staff. If the CONTRACTOR or DBM believes that the standards require updating, or operational changes are needed to enforce the standards, the CONTRACTOR shall meet with the DBM to resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

2.9.11.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22, Section 4.33 of this Agreement, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those requirements or to TENNCARE, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.11.12 Access to Service

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

2.9.12 **Coordination with Medicare**

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

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

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

.

2.9.13 **ICF/MR Services and Alternatives to ICF/MR Services**

2.9.13.1 The CONTRACTOR is not responsible for services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to ICF/MR services (hereinafter referred to as "HCBS MR waiver"). However, to the extent that services available to a member through a HCBS MR waiver are also covered services pursuant to this Agreement, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS MR waiver services may supplement, but not supplant, medically necessary covered services. ICF/MR services and HCBS MR waiver services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

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

2.9.13.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by ICF/MR and HCBS MR waiver providers to minimize disruption and duplication of services.

2.9.14 **Inter-Agency Coordination**

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

2.9.14.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;

2.9.14.2 Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care;

2.9.14.3 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;

2.9.14.4 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;

2.9.14.5 The Division of Mental Retardation Services (DMRS), for the purposes of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;

2.9.14.6 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.14.7 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TennCare and CHOICES, assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process, and facilitating the transition of members during CHOICES implementation and when members are moving to a Grand Region where CHOICES has not yet been implemented;

2.9.14.8 Tennessee Commission on Aging and Disability (TCAD) regarding TCAD's role in monitoring the performance of the AAADs in conducting SPOE functions;

2.9.14.8.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system.

2.9.14.8.2 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the CONTRACTOR shall:

2.9.14.8.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.

2.9.14.8.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.14.8.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within 14 days of the CONTRACTOR's receipt of the IEP.

2.9.14.9 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

12. Section 2.11 shall be deleted in its entirety and replaced with the following:

2.11 PROVIDER NETWORK

2.11.1 General Provisions

2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section 2.6.1 of this Agreement. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the access standards in Attachment III, the Specialty Network Standards in Attachment IV, the Access and Availability for Behavioral Health Services in Attachment V and the requirements herein. These minimum requirements shall not release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.

2.11.1.2 The CONTRACTOR may provide covered physical health and behavioral health services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered physical health and behavioral health services to the members in exchange for payment by the CONTRACTOR for services rendered. The CONTRACTOR shall enter into written agreements with providers to provide covered long-term care services. The CONTRACTOR shall not directly provide long-term care services.

2.11.1.3 When the CONTRACTOR contracts with providers, the CONTRACTOR shall:

2.11.1.3.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program;

2.11.1.3.2 Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Agreement; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;

2.11.1.3.3 Have in place, written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;

2.11.1.3.4 Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination;

2.11.1.3.5 Give affected providers written notice if it declines to include individual or groups of providers in its network; and

2.11.1.3.6 Maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section 2.12 of this Agreement.

2.11.1.4 Section 2.11.1.3 shall not be construed to:

2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Agreement; however, the CONTRACTOR shall contract with nursing facilities pursuant to the requirements of Section 2.11.6 of this Agreement and shall contract with at least two (2) providers for each HCBS to cover each county in the Grand Region, as specified in Section 2.11.6.3;

2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; however, the CONTRACTOR shall reimburse long-term care services in accordance with Sections 2.13.3 and 2.13.4; or

2.11.1.4.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

2.11.1.5 The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

2.11.1.5.1 The member's health status, medical, behavioral health, or long-term care, or treatment options, including any alternative treatment that may be self administered;

2.11.1.5.2 Any information the member needs in order to decide among all relevant treatment options;

2.11.1.5.3 The risks, benefits, and consequences of treatment or non-treatment; or

2.11.1.5.4 The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

2.11.1.7 If a member requests a provider located outside the access standards, and the CONTRACTOR has an appropriate provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall not be responsible for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider.

2.11.1.8 If the CONTRACTOR is unable to meet the access standard for a covered service for which the CONTRACTOR is responsible for providing non-emergency transportation to a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.

2.11.1.8.1 In the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity.

2.11.1.8.2 The CONTRACTOR is not required to provide non-emergency transportation for HCBS, including services provided through a 1915(c) waiver program for persons with mental retardation and HCBS provided through the CHOICES program, except as provided in Section 2.11.1.8.1 above.

2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section 2.9.4.

2.11.1.10 The CONTRACTOR shall monitor provider compliance with access requirements specified in Attachment III, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.7.2.

2.11.1.11 The CONTRACTOR shall use its best efforts to contract with providers to whom the CONTRACTOR routinely refers members.

2.11.1.12 TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify any provider agreement when TENNCARE determines it to be in the best interest of the State.

2.11.1.13 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section 2.30.7.

2.11.2 **Primary Care Providers (PCPs)**

2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member. For CHOICES members, the CONTRACTOR shall develop and implement protocols that address, at a minimum, the roles and responsibilities of the PCP and care coordinator and collaboration between a member's PCP and care coordinator.

2.11.2.2 The CONTRACTOR shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and behavioral health needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the access standards provided in Attachment III.

2.11.2.3 To the extent feasible and appropriate, the CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.

2.11.2.4 The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform all responsibilities of a PCP as defined in Section 1.

2.11.2.5 If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.

2.11.2.6 The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR shall include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.

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

2.11.3 **Specialty Service Providers**

2.11.3.1 Essential Hospital Services and Centers of Excellence

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

2.11.3.1.1.1 Neonatal services;

2.11.3.1.1.2 Perinatal services;

2.11.3.1.1.3 Pediatric services;

2.11.3.1.1.4 Trauma services; and

2.11.3.1.1.5 Burn services.

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

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

2.11.3.2 Physician Specialists

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

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

2.11.3.2.1.2 The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, IV, and V.

2.11.3.3 TENNCARE Monitoring

2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2.30.7.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the

CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

2.11.3.3.2 TENNCARE will require a corrective action plan from the CONTRACTOR when:

2.11.3.3.2.1 Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;

2.11.3.3.2.2 Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or

2.11.3.3.2.3 The member to provider ratio exceeds that listed in Attachment IV.

2.11.3.3.3 TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:

2.11.3.3.3.1 The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;

2.11.3.3.3.2 A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;

2.11.3.3.3.3 For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;

2.11.3.3.3.4 A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;

2.11.3.3.3.5 Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;

2.11.3.3.3.6 Documentation of how these arrangements are communicated to the member; and

2.11.3.3.3.7 Documentation of how these arrangements are communicated to the PCPs.

2.11.4 **Special Conditions for Prenatal Care Providers**

2.11.4.1 The CONTRACTOR shall have a sufficient number of contract providers who accept members in accordance with TennCare access standards in Attachment III so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.

2.11.4.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections 2.7.5.2 and 2.11.4).

2.11.5 **Special Conditions for Behavioral Health Services**

2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity.

2.11.5.2 The CONTRACTOR shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents with a co-occurring mental health and substance abuse disorder.

2.11.5.3 The CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by TENNCARE unless the State approves the use of other crisis service providers.

2.11.6 **Special Conditions for Long-Term Care Providers**

In addition to the requirements in Section 2.11.1 of this Agreement and the access standards specified in Attachment III of this Agreement, the CONTRACTOR shall meet the following requirements for long-term care providers.

2.11.6.1 The CONTRACTOR shall contract with all current nursing facilities (as defined in TCA 71-5-1412(b)), that meet all CMS certification requirements, for a minimum of three (3) years following the effective date of CHOICES implementation. Thereafter, the CONTRACTOR shall contract with a sufficient number of nursing facilities in order to have adequate capacity to meet the needs of CHOICES members for nursing facility services.

2.11.6.2 For community-based residential alternatives, the CONTRACTOR shall demonstrate good faith efforts to develop the capacity to have a travel distance of no more than

sixty (60) miles between a member's community-based residential alternative placement and the member's residence before entering the facility.

2.11.6.3 At a minimum, the CONTRACTOR shall contract with at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county in the Grand Region covered under this Agreement. For HCBS provided in a member's place of residence, the provider does not need to be located in the county of the member's residence but must be willing and able to serve residents of that county. For adult day care, the provider does not have to be located in the county of the member's residence but must meet the access standards for adult day care specified in Attachment III.

2.11.6.4 The CONTRACTOR shall have adequate HCBS provider capacity to meet the needs of each and every CHOICES member in Group 2 and 3 and to provide authorized HCBS within the timeframe prescribed in Sections 2.9.2, 2.9.3, and 2.9.6 of this Agreement. This includes initiating HCBS in the member's plan of care within the timeframes specified in this Agreement and continuing services in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule.

2.11.6.5 Following the first quarter of implementation, TENNCARE will review all relevant reports submitted by the CONTRACTOR, including but not limited to reports that address provider network, service initiation, missed visits, and service utilization. TENNCARE will use the data provided in these reports to establish long-term care provider capacity requirements and develop performance standards, benchmarks and associated liquidated damages for failure to meet the specified performance standards and benchmarks. TENNCARE will notify the CONTRACTOR of the performance standards, benchmarks, and liquidated damages including the timeframe for imposing liquidated damages.

2.11.6.6 The CONTRACTOR shall develop and maintain a network development plan to ensure the adequacy and sufficiency of its provider network. The network development plan shall be submitted to TENNCARE annually, monitored by TENNCARE per the requirements in Section 2.25 of the Agreement, and include the following minimum elements:

2.11.6.6.1 Summary of nursing facility provider network, by county.

2.11.6.6.2 Summary of HCBS provider network, including community-based residential alternatives, by service and county.

2.11.6.6.3 Demonstration of and monitoring activities to ensure that access standards for long-term care services are met, including requirements in Attachment III and in this Section 2.11.6.

2.11.6.6.4 Demonstration of the CONTRACTOR's ongoing activities to track and trend every time a member does not receive initial or ongoing long-term care services in accordance with the requirements of this Agreement due to inadequate provider capacity, identify systemic issues, and implement remediation and quality improvement (QI) activities. This shall include a summary of provider network

capacity issues by service and county, the CONTRACTOR's remediation and QI activities and the targeted and actual completion dates for those activities.

2.11.6.6.5 HCBS network deficiencies (in addition to those specified in Section 2.11.6.6.4 above) by service and by county and interventions to address the deficiencies.

2.11.6.6.6 Demonstration of the CONTRACTOR's efforts to develop and enhance existing community-based residential alternatives (including adult care homes) capacity for elders and/or adults with physical disabilities. The CONTRACTOR shall specify related activities, including provider recruitment activities, and provide a status update on capacity building.

2.11.6.6.7 Where there are deficiencies or as otherwise applicable, annual target increase in HCBS providers by service and county.

2.11.6.6.8 Ongoing activities for HCBS provider development and expansion taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in membership and long-term needs.

2.11.6.7 The CONTRACTOR shall assist in developing an adequate qualified workforce for covered long-term care services. The CONTRACTOR shall develop and implement strategies to increase the pool of available qualified direct care staff and to improve retention of qualified direct care staff. The strategies may include, for example, establishing partnerships with local colleges and technical training schools; establishing partnerships with professional and trade associations and pursuing untapped labor pools such as elders. The CONTRACTOR shall report annually to TENNCARE on the status of its qualified workforce development strategies (see Section 2.30.7.8).

2.11.7 **Safety Net Providers**

2.11.7.1 Federally Qualified Health Centers (FQHCs)

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

2.11.7.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section 2.30.7.9 of this Agreement.

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 SPMI/SED populations, exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with CMHAs.

2.11.7.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in the Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.7.

2.11.8 **Credentialing and Other Certification**

2.11.8.1 Credentialing of Contract Providers

2.11.8.1.1 Except as provided in sections 2.11.8.3 and 2.11.8.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

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

2.11.8.2 Credentialing of Non-Contract Providers

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

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

2.11.8.3 Credentialing of Behavioral Health Entities

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

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

2.11.8.4 Credentialing of Long-Term Care Providers

2.11.8.4.1 The CONTRACTOR shall develop and implement a process for credentialing and recredentialing long-term care providers. The CONTRACTOR's process shall, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, the CONTRACTOR shall ensure that all long-term care providers, including those credentialed/recredentialed in accordance with NCQA Standards and Guidelines for the Accreditation of MCOs, meet applicable State requirements, as specified by TENNCARE.

2.11.8.4.2 To the extent possible the CONTRACTOR shall develop a streamlined credentialing process for nursing facility and HCBS providers enrolled in TennCare prior to the effective date of CHOICES implementation, and, to the extent permitted under NCQA Standards and Guidelines for the Accreditation of MCOs, the CONTRACTOR shall use credentialing requirements that are consistent with the State provider qualifications in place for long-term care providers at CHOICES implementation.

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

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

2.11.8.6 Weight Watchers Centers or Other Weight Management Program

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

2.11.9 **Network Notice Requirements**

2.11.9.1 Member Notification

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

2.11.9.1.1 *Change in PCP*

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

2.11.9.1.2 *PCP Termination*

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

2.11.9.1.3 *Physical Health or Behavioral Health Providers Providing Ongoing Treatment Termination*

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

2.11.9.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been seen and/or treated by the non-PCP provider within the last six (6) months. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

2.11.9.1.5 *Long-Term Care Provider Termination*

If a long-term care provider ceases participation in the CONTRACTOR's MCO the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or is authorized to receive long-term care services from that provider. Notices regarding termination by a nursing facility shall comply with state and federal requirements. The requirement in this Section 2.11.9.1.5 to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances. See Section 2.9.4 of this Agreement regarding requirements for transitioning from a terminating provider to a new provider.

2.11.9.1.6 *Network Deficiency*

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

2.11.9.2 <u>TENNCARE Notification</u>

2.11.9.2.1 *Subcontractor Termination*

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

2.11.9.2.2 *Hospital Termination*

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

2.11.9.2.3 *Other Provider Terminations*

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

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

13. Section 2.12 shall be deleted in its entirety and replaced with the following:

2.12 PROVIDER AGREEMENTS

2.12.1 Provider agreements, as defined in Section 1 of this Agreement, shall be administered in accordance with this Agreement and shall contain or incorporate by reference to the provider handbook all of the items listed in this Section 2.12. Any requirements revised or added to Section 2.12 as part of amendment #4 may, for non-long-term care providers, be incorporated by reference to the provider handbook and included, as appropriate, in the next amendment to provider agreements.

2.12.2 All template provider agreements and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.

2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.

2.12.4 All single case agreements shall be reported to TENNCARE in accordance with Section 2.30.8; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears single case agreements are being used to circumvent the provider agreement review and approval process.

2.12.5 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement.

2.12.6 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.

2.12.7 The CONTRACTOR shall not include covenant-not-to-compete requirements in its provider agreements. The CONTRACTOR shall not execute provider agreements that require that a provider not provide services for any other TennCare MCO.

2.12.8 The CONTRACTOR shall not execute provider agreements that contain compensation terms that discourage providers from serving any specific eligibility category or population covered by this Agreement.

2.12.9 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, except as otherwise provided in Section 2.12.13, at a minimum, meet the following requirements:

2.12.9.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;

2.12.9.2 Specify the effective dates of the provider agreement;

2.12.9.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

2.12.9.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior written approval of the CONTRACTOR;

2.12.9.5 Identify the population covered by the provider agreement;

2.12.9.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

2.12.9.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

2.12.9.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;

2.12.9.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;

2.12.9.10 Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section 2.11 of the CONTRACTOR's Agreement with TENNCARE;

2.12.9.11 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR and include the definition of unreasonable delay as described in Section 2.7.5.2.3 of this Agreement;

2.12.9.12 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

2.12.9.13 Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements;

2.12.9.14 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees shall give TENNCARE, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the

Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;

2.12.9.16 Include medical records requirements found in Section 2.24.6 of this Agreement;

2.12.9.17 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;

2.12.9.18 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;

2.12.9.19 Provide for monitoring, whether announced or unannounced, of services rendered to members;

2.12.9.20 Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;

2.12.9.21 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;

2.12.9.22 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

2.12.9.23 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

2.12.9.24 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;

2.12.9.25 Provide the name and address of the official payee to whom payment shall be made;

2.12.9.26 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;

2.12.9.27 Specify that the CONTRACTOR shall only pay providers for services (1) provided in accordance with the requirements of this Agreement, the CONTRACTOR's policies and procedures implementing this Agreement, and state and federal law and (2) provided to TennCare enrollees who are enrolled with the CONTRACTOR; and specify that the provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service;

2.12.9.28 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;

2.12.9.29 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section 2.22.4 of this Agreement;

2.12.9.30 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;

2.12.9.31 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

2.12.9.32 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.7 of this Agreement;

2.12.9.33 Specify the provider's responsibilities regarding third party liability (TPL) , including the provider's obligation to identify third party liability coverage, including Medicare

and long-term care insurance as applicable, and, except as otherwise provided in the CONTRACTOR's Agreement with TENNCARE, to seek such third party liability payment before submitting claims to the CONTRACTOR;

2.12.9.34 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

2.12.9.34.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and

2.12.9.34.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;

2.12.9.35 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;

2.12.9.36 Require the provider to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;

2.12.9.37 Require that, for CHOICES members, the provider facilitate notification of the member's care coordinator by notifying the CONTRACTOR, in accordance with the CONTRACTOR's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;

2.12.9.38 Require hospitals, including psychiatric hospitals, to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion plan (see Section 2.9.6.7), which shall, include, at a minimum, the hospital's obligation to promptly notify the CONTRACTOR upon admission of an eligible member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or HCBS upon discharge, and how the hospital will engage the CONTRACTOR in the discharge planning process to ensure that members receive the most appropriate and cost-effective medically necessary services upon discharge;

2.12.9.39 Require the provider to conduct background checks in accordance with state law and TennCare policy;

2.12.9.40 As a condition of reimbursement for global procedures codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;

2.12.9.41 Except as otherwise specified in Sections 2.12.11 or 2.12.12, require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under

the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

2.12.9.42 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;

2.12.9.43 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);

2.12.9.44 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any provider agreement in accordance with the terms of the CONTRACTOR's Agreement with TENNCARE (see Section 4.4) and applicable law and regulation;

2.12.9.45 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State.

2.12.9.46 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4.4 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;

2.12.9.47 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);

2.12.9.48 Include a Conflict of Interest clause as stated in Section 4.19 of this Agreement, Gratuities clause as stated in Section 4.23 of this Agreement, and Lobbying clause as stated in Section 4.24 of this Agreement between the CONTRACTOR and TENNCARE;

2.12.9.49 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the

CONTRACTOR. This indemnification may be accomplished by incorporating Section 4.31 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;

2.12.9.50 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 4.33 of this Agreement;

2.12.9.51 Specify provider actions to improve patient safety and quality;

2.12.9.52 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:

2.12.9.52.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and

2.12.9.52.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.12.9.53 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;

2.12.9.54 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;

2.12.9.55 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;

2.12.9.56 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.7.6 of this Agreement. All provider agreements shall contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or

include language to require that these sections be furnished to the provider upon request;

2.12.9.57 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term care services covered by TENNCARE;

2.12.9.58 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

2.12.9.59 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

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

2.12.9.61 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members; and

2.12.9.62 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.

2.12.10 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in 2.12.9 above.

2.12.11 The provider agreement with a nursing facility shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:

2.12.11.1 Require the nursing facility provider to promptly notify the CONTRACTOR, and/or State entity as directed by TENNCARE, of a member's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a member's known circumstances and to notify the CONTRACTOR, and/or State entity as directed by TENNCARE, prior to a member's discharge;

2.12.11.2 Require the nursing facility provider to provide written notice to TENNCARE and the CONTRACTOR in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;

2.12.11.3 Require the nursing facility provider to notify the CONTRACTOR immediately if the nursing facility is considering discharging a member and to consult with the member's care coordinator to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate;

2.12.11.4 Require the nursing facility to notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

2.12.11.5 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the member's third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served;

2.12.11.6 Specify the nursing facility provider's responsibilities regarding patient liability (see Sections 2.6.7 and 2.21.5 of this Agreement), which shall include but not be limited to collecting the applicable patient liability amounts from CHOICES Group 1 members, notifying the member's care coordinator if there is an issue with collecting a member's patient liability, and making good faith efforts to collect payment;

2.12.11.7 Specify the role of the nursing facility provider regarding timely certification and recertification (as applicable) of the member's level of care eligibility for Level I and/or Level II nursing facility care and require the nursing facility provider to cooperate fully with the CONTRACTOR in the completion and submission of the level of care assessment;

2.12.11.8 Require the nursing facility to notify the CONTRACTOR of any change in a member's medical or functional condition that could impact the member's level of care eligibility for the currently authorized level of nursing facility services;

2.12.11.9 Require the nursing facility provider to comply with state and federal laws and regulations applicable to nursing facilities as well as any applicable federal court orders, including but not limited to those that govern admission, transfer, and discharge policies;

2.12.11.10 Require the nursing facility to comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including that a level I screening be completed prior to admission, a level II evaluation be completed prior to admission when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from specialized services;

2.12.11.11 Require the nursing facility to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion and transition plans (see Section 2.9.6.7), which shall, include, at a minimum, the

nursing facility's obligation to promptly notify the CONTRACTOR upon admission or request for admission of an eligible member regardless of payor source for the nursing facility stay; how the nursing facility will assist the CONTRACTOR in identifying residents who may want to transition from nursing facility services to home and community-based care; the nursing facility's obligation to promptly notify the CONTRACTOR regarding all such identified members; and how the nursing facility will work with the CONTRACTOR in assessing the member's transition potential and needs, and in developing and implementing a transition plan, as applicable;

2.12.11.12 Require the nursing facility provider to coordinate with the CONTRACTOR in complying with the requirements in 42 CFR 483.75 regarding written transfer agreements and shall use contract providers when transfer is medically appropriate, except as authorized by the CONTRACTOR or for emergency services;

2.12.11.13 Require the nursing facility provider to have on file a system designed and utilized to ensure the integrity of the member's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

2.12.11.14 Require the nursing facility provider to immediately notify the CONTRACTOR of any change in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

2.12.11.15 Provide that if the nursing facility provider is involuntarily decertified by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services, the provider agreement will automatically be terminated in accordance with federal requirements;

2.12.11.16 For a minimum of three (3) years following the effective date of CHOICES implementation (see Section 2.11.6.1 of this Agreement and TCA 71-5-1412(b)), shall not require the nursing facility provider to have liability insurance in excess of TENNCARE requirements in effect prior to the implementation of CHOICES; and

2.12.11.17 Include language requiring that the provider agreement shall be assignable from the CONTRACTOR to the State, or its designee, at the State's discretion upon written notice to the CONTRACTOR and the affected nursing facility provider. Further, the provider agreement shall include language by which the nursing facility provider agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.12.12 The provider agreement with a HCBS provider shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:

2.12.12.1 Require the HCBS provider to provide at least thirty (30) days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers;

2.12.12.2 In the event that a HCBS provider change is initiated for a member, require that, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR, which may exceed thirty (30) days from the date of notice to the CONTRACTOR;

2.12.12.3 Specify that reimbursement of a HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the member's plan of care as authorized by the CONTRACTOR;

2.12.12.4 Require HCBS providers to immediately report any deviations from a member's service schedule to the member's care coordinator;

2.12.12.5 Require HCBS providers to use the electronic visit verification system specified by the CONTRACTOR in accordance with the CONTRACTOR's requirements;

2.12.12.6 Require that upon acceptance by the HCBS provider to provide approved services to a member as indicated in the member's plan of care, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by the CONTRACTOR in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;

2.12.12.7 Require HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service;

2.12.12.8 Prohibit HCBS providers from requiring a member to choose the provider as a provider of multiple services as a condition of providing any service to the member;

2.12.12.9 Require HCBS providers to comply with critical incident reporting and management requirements (see Section 2.15.8 of this Agreement); and

2.12.12.10 Shall not require the HCBS provider to have liability insurance in excess of TENNCARE requirements in effect prior to the implementation of CHOICES.

2.12.13 The provider agreement with a HCBS provider to provide PERS, assistive technology, minor home modifications, or pest control shall meet the requirements specified in Sections 2.12.9, 2.12.10, and 2.12.12 except that these provider agreements shall not be required to meet the following requirements: Section 2.12.9.9 regarding emergency services; Section 2.12.9.11 regarding delay in prenatal care; Section 2.12.9.12 regarding CLIA; Section 2.12.9.38 regarding hospital protocols; Section 2.12.9.40 regarding reimbursement of obstetric care; Section 2.12.9.52.2 regarding prior authorization of pharmacy; and Section 2.12.9.53 regarding coordination with the PBM.

2.12.14 The provider agreement with a local health department (see Section 2.11.7.3) shall meet the minimum requirements specified in Sections 2.12.9 and 2.12.10 above and shall also specify for the purpose of TENNderCare screening services: (1) that the

local health department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TENNderCare screening services.

2.12.15 The provider agreement for CRG/TPG assessments shall meet the minimum requirements specified in Sections 2.12.9 and 2.12.10 above and shall also specify that all CRG/TPG assessments detailed in Section 2.7.2.9 are completed by State-certified raters and that the assessments are completed within the specified time frames. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination, scored only by State-certified trainers.

14. Section 2.13 shall be deleted in its entirety and replaced with the following:

2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

2.13.1 **General**

2.13.1.1 The CONTRACTOR shall agree to reasonable reimbursement standards to providers for covered services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

2.13.1.2 The CONTRACTOR shall require, as a condition of payment, that the provider (contract or non-contract provider) accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing or patient liability responsibilities due from the enrollee as payment in full for the service.

2.13.1.3 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Agreement, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.

2.13.1.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts (described in Section 2.6.7 and in Attachment II of this Agreement) and patient liability amounts.

2.13.1.5 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements, as applicable, have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2.12.9.60 of this Agreement.

2.13.2 **All Covered Services**

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

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

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

2.13.3 **Nursing Facility Services**

2.13.3.1 The CONTRACTOR shall reimburse contract nursing facility providers at the rate specified by TENNCARE, net of any applicable patient liability amount (see Section 2.6.7).

2.13.3.2 The CONTRACTOR shall reimburse non-contract nursing facility providers as specified in TennCare rules and regulations, net of any applicable patient liability amount (see Section 2.6.7).

2.13.3.3 If, prior to the end date specified by TENNCARE in its approval of Level II nursing facility services, the CONTRACTOR determines that the nursing facility is providing Level I and not Level II nursing facility services, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may adjust payment to the nursing facility to reflect the level of nursing facility services actually provided to the member and shall maintain documentation as specified by TENNCARE to support the payment adjustment.

2.13.4 **HCBS**

2.13.4.1 For covered HCBS and for HCBS that exceed the specified benefit limit and are provided by the CONTRACTOR as a cost effective alternative (see Section 2.6.5), the CONTRACTOR shall reimburse contract HCBS providers, including community-based residential alternatives, at the rate specified by TENNCARE.

2.13.4.2 The CONTRACTOR shall reimburse non-contract HCBS providers as specified in TennCare rules and regulations.

2.13.4.3 For HCBS that are not otherwise covered but are offered by the CONTRACTOR as a cost effective alternative to nursing facility services (see Section 2.6.5), the CONTRACTOR shall negotiate the rate of reimbursement.

2.13.4.4 The CONTRACTOR shall reimburse consumer-directed workers in accordance with Sections 2.9.6.7 and 2.26 of this Agreement.

2.13.5 **Hospice**

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

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

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

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

2.13.6 **Behavioral Health Crisis Service Teams**

2.13.6.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services on a monthly basis at a rate to be determined and set by the State. The rate shall be factored into the CONTRACTOR's capitation payments.

2.13.6.2 The CONTRACTOR shall assume financial liability for crisis respite and crisis stabilization services.

2.13.7 **Local Health Departments**

2.13.7.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.7.3 and 2.12.1.3) for TENNderCare screenings to members under age twenty-one (21) at the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

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

2.13.7.2 TENNCARE may conduct an audit of the CONTRACTOR's reimbursement methodology and related processes on an annual basis to verify compliance with this

requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is not the required reimbursement rate.

2.13.8 **Physician Incentive Plan (PIP)**

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

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

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

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

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

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

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

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

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

2.13.9 **Emergency Services Obtained from Non-Contract Providers**

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

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

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

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

2.13.10.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section 2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested (see Section 2.4.4.5). In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

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

2.13.10.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6), as determined by the State and shown in the enrollment file furnished by TENNCARE to the CONTRACTOR.

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

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

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

2.13.11.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6), as determined by the State and shown in the enrollment file furnished by TENNCARE to the CONTRACTOR.

2.13.12 **Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider**

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider. The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6) and that were authorized by the CONTRACTOR.

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

2.13.13.1 With the exception of circumstances described in Section 2.13.12 when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

2.13.13.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary or for long-term care services for which the member was not eligible (see Section 2.6).

2.13.14 **Covered Services Ordered by Medicare Providers for Dual Eligibles**

2.13.14.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR shall pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contract provider:

2.13.14.1.1 The ordered service requires prior authorization; and

2.13.14.1.2 Dually eligible enrollees have been clearly informed of the contract provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and

2.13.14.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.

2.13.14.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.14.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

2.13.15 **Transition of New Members**

The CONTRACTOR shall pay for the continuation of covered services for new members pursuant to the requirements in Section 2.9.2 regarding transition of new members.

2.13.16 **Transition of Members Receiving Long-Term Care Services at the Time of CHOICES Implementation**

The CONTRACTOR shall pay for the continuation of covered long-term care services for transitioning CHOICES members pursuant to the requirements in Section 2.9.3 regarding transition of members receiving long-term care services at the time of CHOICES implementation.

2.13.17 **Transition of Care**

In accordance with the requirements in Section 2.9.4.1 of this Agreement, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section 2.9.4.1.

2.13.18 **Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR**

2.13.18.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that is related to the CONTRACTOR than the CONTRACTOR pays to providers and subcontractors that are not related to the CONTRACTOR. For purposes of this subsection, “related to” means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the CONTRACTOR, an affiliate (see definition in Section 1 of this Agreement) of the CONTRACTOR, or the CONTRACTOR’s management company as well as providers or subcontractors that the CONTRACTOR, an affiliate of the CONTRACTOR or the CONTRACTOR’s management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.18.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be considered non-allowable payments for covered services and shall be excluded from medical expenses reported in the MLR report required in Section 2.30.15.3.1.

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

2.13.19 **1099 Preparation**

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

2.13.20 **Payments to the FEA**

The CONTRACTOR shall reimburse the Fiscal Employer Agent (FEA) for authorized HCBS provided by consumer-directed workers as specified in the subcontract between the CONTRACTOR and the FEA (see Section 2.26.6). TENNCARE will pay the FEA the administrative fees specified in the contract between TENNCARE and the FEA.

15. Section 2.14 shall be deleted in its entirety and replaced with the following:

2.14 UTILIZATION MANAGEMENT (UM)

2.14.1 **General**

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

2.14.1.2 The CONTRACTOR's UM program shall include distinct policies and procedures regarding long-term care services and shall specify the responsibilities and scope of authority of care coordinators in authorizing long-term care services and in submitting service authorizations to providers and/or the FEA for service delivery.

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

2.14.1.4 The UM program shall have criteria that:

2.14.1.4.1 Are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible;

2.14.1.4.2 Are applied based on individual needs;

2.14.1.4.3 Are applied based on an assessment of the local delivery system;

2.14.1.4.4 Involve appropriate practitioners in developing, adopting and reviewing them; and

2.14.1.4.5 Are annually reviewed and up-dated as appropriate.

2.14.1.5 For long-term care services, the CONTRACTOR's UM program shall have criteria that are consistent with the guiding principles set forth in TCA 71-5-1402 and shall take into consideration the member's preference regarding cost-effective long-term care services and settings.

2.14.1.6 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

2.14.1.7 Except as provided in Section 2.6.1.3, the CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.

2.14.1.8 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

2.14.1.9 The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

2.14.1.10 As part of the provider survey required by Section 2.18.7.4, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.

2.14.1.11 <u>Inpatient Care</u>

The CONTRACTOR shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs 2.14.1.11.1 through 2.14.1.11.5 below:

2.14.1.11.1 Pre-admission certification process for non-emergency admissions;

2.14.1.11.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;

2.14.1.11.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

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

2.14.1.11.5 Prospective review of same day surgery procedures.

2.14.1.12 Nursing Facility

2.14.1.12.1 If a member is enrolled in CHOICES Group 1, the CONTRACTOR shall authorize and initiate nursing facility services for that member in accordance with Section 2.9.6. However, if, prior to nursing facility admission, the member chooses to receive HCBS instead of nursing facility services and is enrolled in Group 2 pursuant to Section 2.9.6, the CONTRACTOR shall authorize and initiate HCBS in accordance with Section 2.9.6. Once the member has been admitted to a nursing facility the CONTRACTOR may, as appropriate, implement its nursing facility-to-community transition process pursuant to Section 2.9.6.8 of this Agreement.

2.14.1.12.2 The CONTRACTOR shall ensure that CHOICES members who have been determined by TENNCARE to be eligible for Level II nursing facility care are authorized to receive Level II nursing facility care for the period specified by TENNCARE. The CONTRACTOR shall monitor the member's condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires Level II nursing facility care, the CONTRACTOR may submit to TENNCARE a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request and shall only transition the member to Level I nursing facility care once the request has been approved by TENNCARE.

2.14.1.13 Emergency Department (ED) Utilization

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

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

2.14.1.13.2 Enroll non-CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in MCO case management and may use the information to identify members who may be eligible for CHOICES in accordance with the requirements in Section 2.9.6.3. if appropriate;

2.14.1.13.3 For CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period, the care coordinator shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps. For CHOICES members in Group 1, appropriate next steps may include communication with the nursing facility to determine interventions to better manage the member's condition. For CHOICES members in Groups 2 and 3, appropriate next steps may include modifications to the member's plan of care in order to address service delivery needs and better manage the member's condition.

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

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

2.14.1.14 Hospitalizations and Surgeries

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

2.14.2 **Prior Authorization for Physical Health and Behavioral Health Covered Services**

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

2.14.2.2 Prior authorization for home health nurse, home health aide and private duty nursing services shall comply with TennCare rules and regulations.

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

2.14.3 **Referrals for Physical Health and Behavioral Health**

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

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

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

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

2.14.3.5 Referral Provider Listing

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

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section 2.17.8.

2.14.3.5.3 As required in Section 2.30.10.7, the CONTRACTOR shall submit to TENNCARE a copy of the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.14.4 **Exceptions to Prior Authorization and/or Referrals for Physical Health and Behavioral Health**

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section 1) in accordance with 42 CFR 422.113.

2.14.4.2 TENNderCare

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

2.14.4.3 Access to Women's Health Specialists

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

2.14.4.4 Behavioral Health Services

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

2.14.4.5 Transition of New Members

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

2.14.5 **Authorization of Long-Term Care Services**

2.14.5.1 The CONTRACTOR shall have in place an authorization process for all covered long-term care services and cost effective alternative services that is separate from but integrated with the CONTRACTOR's prior authorization process for covered physical health and behavioral health services (See section 2.9.6 of this Agreement).

2.14.5.2 The CONTRACTOR shall authorize and initiate all long-term care services for CHOICES members within the timeframes specified in Sections 2.9.2, 2.9.3, and 2.9.6 of this Agreement.

2.14.5.3 The CONTRACTOR shall not require that HCBS be ordered by a treating physician, but may consult with the treating physician as appropriate regarding the member's physical health, behavioral health, and long-term care needs and in order to facilitate communication and coordination regarding the member's physical health, behavioral health, and long-term care services.

2.14.5.4 For non-CHOICES members receiving care in non-contract nursing facilities authorized by the CONTRACTOR as a cost-effective alternative, the CONTRACTOR shall reimburse services in accordance with its authorization until such time that the member is no longer eligible for services, is enrolled in CHOICES, or such care is no longer medically necessary or cost-effective.

2.14.6 **Transition of Members Receiving Long-term Care Services at the time of CHOICES Implementation**

For members enrolling in CHOICES as of the date of CHOICES implementation, the CONTRACTOR shall be responsible for continuing to provide the long-term care services previously authorized for the member, as specified in Section 2.9.3 of this Agreement.

2.14.7 **Notice of Adverse Action Requirements**

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

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

2.14.7.3 The CONTRACTOR shall issue appropriate notice prior to any CONTRACTOR-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations regarding members' transfer or discharge from nursing facilities.

2.14.8 **Medical History Information Requirements**

2.14.8.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. With respect to HCBS which are not primarily medical in nature, pertinent medical history shall include assessments, case notes, and documentation of service delivery by HCBS providers. Medical information from the treating physician may also be pertinent in better understanding the member's functional needs. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

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

2.14.9 **PCP Profiling**

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

2.14.9.1 Utilization of Non-Contract Providers

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

2.14.9.2 Specialist Referrals

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

2.14.9.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.9.5, members who establish a pattern of accessing emergency room services shall be referred to MCO case management as appropriate for follow-up.

2.14.9.4 Inpatient Admissions

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

2.14.9.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section 2.9.10 of this Agreement.

2.14.9.6 Advanced Imaging Procedures

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

2.14.9.7 PCP Visits

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

16. Section 2.15 shall be deleted in its entirety and replaced with the following:

2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

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

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

2.15.1.1.1 Address physical health, behavioral health, and long-term care services;

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

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

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

2.15.1.1.5 Have an annual work plan;

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

2.15.1.1.7 Be evaluated annually and updated as appropriate.

2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.

2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.

2.15.1.4 Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.1.5 The CONTRACTOR shall use the results of QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members.

2.15.1.6 The CONTRACTOR shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified.

2.15.1.7 In addition to QM/QI activities as defined in this Section 2.15, the CONTRACTOR's QM/QI program shall incorporate all applicable reporting and monitoring requirements and activities, including but not limited to such activities specified in

Sections 2.25, 2.30, and 2.9.6.12 of this Agreement; and shall include discovery and remediation of individual findings, as well as identification and implementation of strategies to make systemic improvements in the delivery and quality of care.

2.15.2 **QM/QI Committee**

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.

2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

2.15.3 **Performance Improvement Projects (PIPs)**

2.15.3.1 The CONTRACTOR shall perform at least two (2) clinical and three (3) non-clinical PIPs.

2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.

2.15.3.1.2 Two (2) of the three (3) non-clinical PIPs shall be in the area of long-term care. For each of these PIPs TENNCARE will select the study topic, define the study question, select the study indicator(s), and define the methodology for measuring the study indicator(s), including the sampling methodology, data collection, and data analysis. TENNCARE has the discretion to change the PIPs each year (including changing the study topic, study question, study indicator(s), and/or methodology) and to require up to two (2) additional non-clinical PIPs, for a total of five (5) non-clinical PIPs at any one time. TENNCARE will consult with MCOs and other stakeholders in developing PIPs.

2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:

2.15.3.2.1 Rationale for selection as a quality improvement activity;

2.15.3.2.2 Specific population targeted, include sampling methodology if relevant;

2.15.3.2.3 Metrics to determine meaningful improvement and baseline measurement;

2.15.3.2.4 Specific interventions (enrollee and provider);

2.15.3.2.5 Relevant clinical practice guidelines; and

2.15.3.2.6 Date of re-measurement.

2.15.3.3 The CONTRACTOR shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

2.15.3.4 The CONTRACTOR shall report on PIPs as required in Section 2.30.11.2, Reporting Requirements.

2.15.3.5 After three (3) years, the CONTRACTOR shall, using evaluation criteria established by TENNCARE, determine if one or all of the non-long-term care PIPs should be continued. Prior to discontinuing a non-long-term care PIP, the CONTRACTOR shall identify a new PIP and must receive TENNCARE's approval to discontinue the previous PIP and perform the new PIP.

2.15.4 **Clinical Practice Guidelines**

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

2.15.5 **NCQA Accreditation**

2.15.5.1 The CONTRACTOR shall obtain NCQA accreditation by November 30, 2009 and shall maintain it thereafter. Any accreditation status granted by NCQA under the New Health Plan (NHP) program or the MCO Introductory Survey option will not be acknowledged by TENNCARE. Accreditation obtained under the NCQA Full Accreditation Survey or Multiple Product Survey options will be acknowledged by TENNCARE if the TennCare product is specifically included in the NCQA survey. TENNCARE will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by NCQA, in the accreditation of the CONTRACTOR. In order to ensure that the CONTRACTOR is making forward progress, TENNCARE shall require that the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2007	
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	December 15, 2007

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2008	
Submit copy of signed NCQA Survey contract to TENNCARE	January 15, 2008
Purchase NCQA ISS Tool for 2009 MCO Accreditation Survey	August 15, 2008
Copy of signed contract with NCQA approved vendor to perform 2009 CAHPS surveys (Adult, Child and Children with Chronic Conditions to TENNCARE)	November 15, 2008
Copy of signed contract with NCQA approved vendor to perform 2009 HEDIS Audit to TENNCARE (The CONTRACTOR must perform the complete Medicaid HEDIS Data Set with the exception of dental related measures)	November 15, 2008
CALENDAR YEAR 2009	
Notify TENNCARE of date for ISS Submission and NCQA On-site review	January 15, 2009
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor, TENNCARE, and the EQRO	February 15, 2009
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TENNCARE	June 15, 2009
Finalize preparations for NCQA Survey (Final payment must be submitted to NCQA sixty (60) calendar days prior to submission of ISS)	Notify TennCare of final payment within five (5) business days of submission to NCQA.
Submission of ISS to NCQA	Notify TennCare within five (5) business days of submission to NCQA.
NCQA Survey Completed and copy of NCQA Final Report to TENNCARE: • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within twelve (12) months. • Accreditation Denied – Results in termination of this Agreement.	November 30, 2009

2.15.5.2 If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 4.4 of this Agreement.

2.15.5.3 Failure to obtain NCQA accreditation by November 30, 2009 and maintain accreditation thereafter shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 4.4 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from NCQA and may result in termination of this Agreement in accordance with Section 4.4 of this Agreement.

2.15.6 **HEDIS and CAHPS**

2.15.6.1 Annually, beginning with HEDIS 2009, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The CONTRACTOR shall also complete specified Medicare HEDIS measures for CHOICES members based on the Medicare CAHPS, as identified by the State. The HEDIS measure results, except the Medicare HEDIS measures for CHOICES members, shall be reported separately for each Grand Region in which the CONTRACTOR operates. The Medicare HEDIS measures for CHOICES members may be reported statewide. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

2.15.6.2 Annually, beginning in 2009, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. With regard to the CAHPS adult survey, this shall include conducting the survey for non-CHOICES members and conducting the survey with additional survey questions from the Medicare CAHPS, as identified by TENNCARE, to CHOICES members in Groups 2 and 3. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above, including the CAHPS adult survey with supplemental Medicare CAHPS questions for CHOICES members. The survey results for non-CHOICES members shall be reported separately for each Grand Region in which the CONTRACTOR operates. The survey results for CHOICES members may be reported statewide. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

2.15.7 **Medicare Health Outcomes Survey (HOS)**

Annually, beginning in 2010, the CONTRACTOR shall conduct the Health Outcomes Survey (HOS) for a representative sample of CHOICES members in Groups 2 and 3. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to administer HOS surveys. The CONTRACTOR's vendor shall administer the Baseline HOS each year as well as a follow-up survey two (2) years after each Baseline HOS for the baseline cohort. The CONTRACTOR and its vendor shall comply with applicable CMS and NCQA requirements and protocols regarding administering and reporting HOS. The CONTRACTOR shall submit final survey data files to TENNCARE. The CONTRACTOR shall provide the survey results

statewide. TENNCARE will test, clean, and score the data and develop reports (see Section 2.25.9.2).

2.15.8 **Critical Incident Reporting and Management**

2.15.8.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting, including: community-based residential alternatives; adult day care centers; other HCBS provider sites; and a member's home, if the incident is related to the provision of covered HCBS.

2.15.8.2 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS.

2.15.8.3 Critical incidents shall include but not be limited to the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section 2.15.8.1 above):

2.15.8.3.1 Unexpected death of a CHOICES member;

2.15.8.3.2 Suspected physical or mental abuse of a CHOICES member;

2.15.8.3.3 Theft or financial exploitation of a CHOICES member;

2.15.8.3.4 Severe injury sustained by a CHOICES member;

2.15.8.3.5 Medication error involving a CHOICES member;

2.15.8.3.6 Sexual abuse and/or suspected sexual abuse of a CHOICES member; and

2.15.8.3.7 Abuse and neglect and/or suspected abuse and neglect of a CHOICES member.

2.15.8.4 The CONTRACTOR shall require its staff and contract HCBS providers to report, respond to, and document critical incidents as specified by the CONTRACTOR. This shall include, but not be limited to the following:

2.15.8.4.1 Requiring that the CONTRACTOR's staff and contract HCBS providers report critical incidents to the CONTRACTOR in accordance with applicable requirements. The CONTRACTOR shall develop and implement a critical incident reporting process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the CONTRACTOR shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

2.15.8.4.2 Requiring that suspected abuse, neglect, and exploitation of members who are adults is immediately reported in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of members who are children is immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.

2.15.8.4.3 Requiring that its staff and contract HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

2.15.8.4.4 Requiring that contract HCBS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the CONTRACTOR. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) days after the date of the incident. The CONTRACTOR shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

2.15.8.4.5 Requiring that its staff and contract HCBS providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, APS, CPS, and law enforcement).

2.15.8.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in a accordance with Section 2.15.8.4.1, investigating critical incidents, and submitting a report on investigations to the CONTRACTOR; training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.8.4 as well as TENNCARE's contract with the fiscal employer agent and the model subcontract between the CONTRACTOR and the FEA (see Section 2.26 of this Agreement).

2.15.8.4.7 Reviewing the FEA's reports regarding investigations of critical incidents and follow-up with the FEA as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

2.15.8.4.8 Providing appropriate training and taking corrective action as needed to ensure its staff, contract HCBS providers, the FEA, and workers comply with critical incident requirements.

2.15.8.4.9 Conducting oversight, including but not limited to oversight of its staff, contract HCBS providers, and the FEA, to ensure that the CONTRACTOR's policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

2.15.8.5 The CONTRACTOR shall report to TENNCARE any death and any incident that could significantly impact the health or safety of a member (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.

2.15.8.6 As specified in Section 2.30.11.7, the CONTRACTOR shall submit monthly reports to TENNCARE regarding all critical incidents.

17. Section 2.17 shall be deleted in its entirety and replaced with the following:

2.17 MEMBER MATERIALS

2.17.1 Prior Approval Process for All Member Materials

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials) as well as proposed health education and outreach activities. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, Section 2.17 and Section 2.7.4, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

2.17.1.2 All member materials shall be submitted to TENNCARE on paper and electronic file media, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement shall be submitted for approval; however, unless otherwise requested by TENNCARE, an electronic file for these materials is not required. The electronic files shall be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.

2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.

2.17.1.4 Once member materials have been approved in writing by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version (PDF) of the final printed product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Should TENNCARE request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.

2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for written approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.

2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

2.17.2 **Written Material Guidelines**

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

2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;

2.17.2.2 All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved in writing by TENNCARE;

2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 4.32.1;

2.17.2.4 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:

2.17.2.4.1 The Seal of the State of Tennessee;

2.17.2.4.2 The TennCare name unless the initials "SM" denoting a service mark, is superscripted to the right of the name (TennCare^{sm});

2.17.2.4.3 The word "free" unless the service is at no cost to all members. If members have cost sharing or patient liability responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; and

2.17.2.4.4 The use of phrases to encourage enrollment such as "keep your doctor" implying that enrollees can keep all of their providers. Enrollees in TennCare shall not be led to think that they can continue to go to their current provider, unless that particular provider is a contract provider with the CONTRACTOR's MCO;

2.17.2.5 All vital CONTRACTOR documents shall be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR documents shall be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;

2.17.2.6 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;

2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member; and

2.17.2.8 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2.17.3 **Distribution of Member Materials**

2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Agreement. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, identification cards, and CHOICES member education materials.

2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section 2.17, to members in order to promote health and/or educate enrollees.

2.17.4 **Member Handbooks**

2.17.4.1 The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.

2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section 2.4.5 and at least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.

2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) shall be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.

2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter to all contract providers and the FEA as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers and to the FEA, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.

2.17.4.5 The CONTRACTOR shall develop a supplement for the member handbook that includes information regarding the CHOICES program. The supplement shall include the information specified in Section 2.17.4.7 that is not currently included in the member handbook, as determined by TENNCARE.

2.17.4.5.1 The CONTRACTOR shall distribute the supplement to all existing members, contract providers, and the FEA after TENNCARE has issued member notices regarding CHOICES implementation but prior to the implementation date of CHOICES in the Grand Region covered by this Agreement, to new members in accordance with Section 2.17.4.2 above, and to all contract providers and the FEA in accordance with 2.17.4.4 above. The CONTRACTOR shall distribute the supplement until the member handbook is revised to include the CHOICES program, which shall be no later than the date specified by TENNCARE.

2.17.4.6 The CONTRACTOR shall print, disseminate and review with each CHOICES member participating in consumer direction of HCBS a consumer direction handbook developed by TENNCARE. In the event of material revisions to the consumer direction handbook, the CONTRACTOR shall immediately disseminate and review with each CHOICES member participating in consumer direction key changes as reflected in the new and revised consumer direction handbook.

2.17.4.7 Each member handbook shall, at a minimum, be in accordance with the following guidelines:

2.17.4.7.1 Shall be in accordance with all applicable requirements as described in Section 2.17.2 of this Agreement;

2.17.4.7.2 Shall include a table of contents;

2.17.4.7.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment, of PCP assignment, and of care coordinator assignment for CHOICES members;

2.17.4.7.4 Shall include an explanation of how members can request to change PCPs;

2.17.4.7.5 Shall include a description of services provided including benefit limits, the consequences of reaching a benefit limit, non-covered services, and use of non-contract providers, including that members are not entitled to a fair hearing about non-covered services and that members shall use contract providers except in specified circumstances;

2.17.4.7.6 Shall explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, and that service authorization is required for all long-term care services; that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired;

2.17.4.7.7 Shall include a statement advising members that the CONTRACTOR may choose to provide certain non-covered services to a particular member when the CONTRACTOR determines that such non-covered services are an appropriate and more cost-effective way of meeting the member's needs than other covered services that would otherwise be provided; a member is not entitled to receive these non-covered services; the decision to provide or not provide these services to a particular member is at the sole discretion of the CONTRACTOR; and if the CONTRACTOR does not provide one of these non-covered services to a member, the member is not entitled to a fair hearing regarding the decision;

2.17.4.7.8 Shall include descriptions of the Medicaid Benefits, Standard Benefits, and the covered long-term care services for CHOICES members, by CHOICES group.

2.17.4.7.9 Shall include a description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

2.17.4.7.10 Shall include information about preventive services for adults and children, including TENNderCare, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;

2.17.4.7.11 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;

2.17.4.7.12 Shall include information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3, including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

2.17.4.7.13 Shall include information on care coordination for CHOICES members, including but not limited to the role of the care coordinator, level of care assessment and reassessment, needs assessment and reassessment, and care planning, including the development of a plan of care for members in CHOICES Groups 2 and 3;

2.17.4.7.14 Shall include information on the right of CHOICES members to request an objective review by the State of their needs assessment and/or care planning processes and how to request such a review;

2.17.4.7.15 Shall include information regarding consumer direction of HCBS, including but not limited to the roles and responsibilities of the member or the member's representative, the services that can be directed, the member's right to participate in or voluntarily withdraw from consumer direction at any time, the role of and services provided by the FEA, as well as a statement that voluntary or involuntary withdrawal from consumer direction will not affect a member's eligibility for CHOICES;

2.17.4.7.16 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;

2.17.4.7.17 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse line. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse line when they have questions as to whether they should go to the emergency room;

2.17.4.7.18 Shall include information on how to access a care coordinator, including the ability to access a care coordinator after regular business hours through the twenty-four (24) hour nurse triage/advice line.

2.17.4.7.19 Shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;

2.17.4.7.20 Shall include information about the Long-Term Care Ombudsman Program;

2.17.4.7.21 Shall include information about the CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES program and how to contact the consumer advocate for assistance;

2.17.4.7.22 Shall include information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq*.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.), including the phone numbers to call to report suspected abuse/neglect;

2.17.4.7.23 Shall include complaint and appeal procedures as described in Section 2.19 of this Agreement;

2.17.4.7.24 Shall include notice that in addition to the member's right to file an appeal directly to TENNCARE for adverse actions taken by the CONTRACTOR, the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;

2.17.4.7.25 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;

2.17.4.7.26 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;

2.17.4.7.27 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section 2.9.2 of this Agreement;

2.17.4.7.28 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR, TENNCARE, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information;

2.17.4.7.29 Shall include notice that a new member may request to change MCOs at anytime during the forty-five (45) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.7.30 Shall include notice that the member may change MCOs at the next choice period as described in Section 2.4.7.2.2 of this Agreement and shall have a forty-five (45) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.7.31 Shall include notice that the member has the right to ask TENNCARE to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so;

2.17.4.7.32 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;

2.17.4.7.33 Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program, including CHOICES, as well as the service/information that may be obtained from each line;

2.17.4.7.34 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.4.7.35 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;

2.17.4.7.36 Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section 2.17.8.2);

2.17.4.7.37 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

2.17.4.7.38 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

2.17.4.7.39 Shall include information on appropriate prescription drug usage (see Section 2.9.10); and

2.17.4.7.40 Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

2.17.5 **Quarterly Member Newsletter**

2.17.5.1 General Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 Teen/Adolescent Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

2.17.5.2.1 The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and

2.17.5.2.1.1.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

2.17.5.2.1.1.3 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.3.2 At least one specific article targeted to CHOICES members;

2.17.5.3.3 Notification regarding the CHOICES program, including a brief description and whom to contact for additional information;

2.17.5.3.4 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.5.3.5 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;

2.17.5.3.6 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;

2.17.5.3.7 Information about appropriate prescription drug usage;

2.17.5.3.8 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and

2.17.5.3.9 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."

2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 2.30.1.3 of this Agreement.

2.17.6 **Identification Card**

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

2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;

2.17.6.2 Phone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term care services;

2.17.6.3 Descriptions of procedures to be followed for emergency or special services;

2.17.6.4 The member's identification number;

2.17.6.5 The member's name (First, Last and Middle Initial);

2.17.6.6 The member's date of birth;

2.17.6.7 The member's enrollment effective date;

2.17.6.8 Co-payment information;

2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier;

2.17.6.10 The words "Medicaid" or "Standard" based on eligibility; and

2.17.6.11 For CHOICES members, the word "CHOICES."

2.17.7 **CHOICES Member Education Materials**

2.17.7.1 The CONTRACTOR shall explain and provide member education materials to each CHOICES member (see Section 2.9.6.9.6.4.2).

2.17.7.2 The CONTRACTOR shall update and re-print the CHOICES member education materials as specified and with advance notice by TENNCARE. The revised materials shall be submitted to TENNCARE for review and approval. Upon TENNCARE approval, the CONTRACTOR shall immediately distribute the updated materials to all CHOICES members.

2.17.7.3 The materials shall comply with all state and federal requirements and, at a minimum, shall include:

2.17.7.3.1 A description of the CHOICES program, including the CHOICES Groups;

2.17.7.3.2 Information on CHOICES groups and the covered long-term care services for each CHOICES group, including HCBS benefit limits;

2.17.7.3.3 A general description of care coordination and the role of the care coordinator;

2.17.7.3.4 Information about contacting and changing the member's care coordinator, including but not limited to how to contact the care coordinator, how and when the member will be notified of who the assigned care coordinator is, and the procedure for making changes to the assigned care coordinator, whether initiated by the CONTRACTOR or requested by the member;

2.17.7.3.5 Information about the CHOICES consumer advocate, including but not limited to the role of the CHOICES consumer advocate and how to contact the consumer advocate for assistance;

2.17.7.3.6 Information and procedures on how to report suspected abuse and neglect (including abuse, neglect and/or exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children), including the phone numbers to call to report suspected abuse and neglect;

2.17.7.3.7 Information about estate recovery;

2.17.7.3.8 The procedure on how to obtain member materials in alternative formats for members with special needs and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the member;

2.17.7.3.9 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line;

2.17.7.3.10 Information about the member's right to choose between nursing facility and HCBS if the member qualifies for nursing home care and if the member's needs can be safely and effectively met in the community and at a cost that does not exceed the member's cost neutrality cap;

2.17.7.3.11 A description of the care coordinator's role and responsibilities for CHOICES Group 1 members, which at a minimum shall include:

2.17.7.3.11.1 Performing needs assessments as deemed necessary by the CONTRACTOR;

2.17.7.3.11.2 Participating in the nursing facility's care planning process;

2.17.7.3.11.3 Coordinating the member's physical health, behavioral health, and long-term care needs;

2.17.7.3.11.4 Conducting face-to-face visits every six (6) months;

2.17.7.3.11.5 Conducting level of care reassessments; and

2.17.7.3.11.6 Determining the member's interest in transition to the community and facilitating such transition, as appropriate.

2.17.7.3.12 Information for Group 1 members about patient liability responsibilities including the potential consequences of failure to comply with patient liability requirements, including loss of the member's nursing facility provider, disenrollment from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

2.17.7.3.13 Information for Group 1 members about the CONTRACTOR's nursing facility transition process;

2.17.7.3.14 A statement advising members in Groups 2 and 3 that the CONTRACTOR may choose to provide certain non-covered services to a particular member when the CONTRACTOR determines that such services are an appropriate and more cost-effective way of meeting the member's needs than other covered services that would otherwise be provided; a member is not entitled to receive these non-covered services; the decision to provide or not provide these non-covered services to a particular member is at the sole discretion of the CONTRACTOR; and if the CONTRACTOR does not provide one of these non-covered services to a member, the member is not entitled to a fair hearing regarding the decision;

2.17.7.3.15 A statement advising members in Group 2 that the cost of providing HCBS, home health, and private duty nursing shall not exceed the member's cost neutrality cap, and that the cost neutrality cap reflects the projected cost of providing nursing facility services to the member;

2.17.7.3.16 A statement advising members in Group 3 that the cost of providing HCBS, excluding home modification, to members in CHOICES Group 3 shall not exceed the expenditure cap;

2.17.7.3.17 An explanation for members in Group 2 of what happens when a member is projected to exceed his/her cost neutrality cap, which shall include the following: The CONTRACTOR will first work with the member to modify the member's plan of care to safely and effectively meet the member's needs in the community and at a cost that is less than the member's cost neutrality cap; if that is not possible, the member will be transitioned to a more appropriate setting (a nursing facility); and if the member declines to move to a more appropriate setting, the member may be disenrolled from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, may lose eligibility for TennCare;

2.17.7.3.18 A statement advising CHOICES members in Group 3 that the CONTRACTOR will deny HCBS in excess of the expenditure cap;

2.17.7.3.19 A statement advising members that HCBS provided by the CONTRACTOR to CHOICES members will build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance;

2.17.7.3.20 A description of the care coordinator's role and responsibilities for CHOICES Group 2 and 3 members, which at a minimum shall include:

2.17.7.3.20.1 Conducting an individualized, comprehensive needs assessment;

2.17.7.3.20.2 Coordinating a care plan team and facilitating the development of a plan of care;

2.17.7.3.20.3 Coordinating the identification of the member's physical health, behavioral health and long-term care needs and coordinating services to meet those needs;

2.17.7.3.20.4 Implementing the authorized plan of care, including ensuring the timely delivery of services in accordance with the plan of care;

2.17.7.3.20.5 Providing assistance in resolving any concerns about service delivery or providers;

2.17.7.3.20.6 Explanation of the minimum contacts a care coordinator is required to make and a statement that the care coordinator may be contacted as often as the member needs to contact the care coordinator;

2.17.7.3.20.7 Completing level of care and needs reassessments and updating the plan of care; and

2.17.7.3.20.8 Ongoing monitoring of service delivery to ensure that any service gaps are immediately addressed and that provided services meet the member's needs;

2.17.7.3.21 Information about the right of members in Groups 2 and 3 to request an objective review by the State of his/her needs assessment and/or care planning processes and how to make such a request;

2.17.7.3.22 Information for members in Groups 2 and 3 on consumer direction of HCBS, including but not limited to the roles and responsibilities of the member; the ability of the member to select a representative and who can be a representative; the services that can be directed; the member's right to participate in and voluntarily withdraw from consumer direction at any time; how to choose to participate in consumer direction; the role of the FEA; who can/cannot be hired by the member to perform the services, and when a family member can be paid to provide care and applicable limitations thereto; and

2.17.7.3.23 Information for members in Groups 2 and 3 regarding self-direction of health care tasks.

2.17.8 **Provider Directories**

2.17.8.1 The CONTRACTOR shall distribute general provider directories (see Section 2.17.8.5 below) to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date.

2.17.8.2 The CONTRACTOR shall provide the CHOICES provider directory (see Section 2.17.8.6 below) to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than thirty (30) days from notice of CHOICES enrollment.

2.17.8.3 The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members at least on an annual basis. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) general provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory shall be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

2.17.8.4 Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.

2.17.8.5 The CONTRACTOR shall develop and maintain a general provider directory, which shall be distributed to all members. The general provider directory shall include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; and identification of whether or not a provider performs TENNderCare screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.

2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES provider directory that includes long-term care providers. The CHOICES provider directory, which shall be provided to all CHOICES members, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) HCBS providers with the name, location, telephone number, and type of services by county of each provider.

2.17.9 **Additional Information Available Upon Request**

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

2.17.9.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and

2.17.9.2 Information regarding physician incentive plans, including but not limited to:

2.17.9.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;

2.17.9.2.2 The type of incentive arrangement; and

2.17.9.2.3 Whether stop-loss protection is provided.

18. Section 2.18 shall be deleted in its entirety and replaced with the following:

2.18 CUSTOMER SERVICE

2.18.1 **Member Services Toll-Free Phone Line**

2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, concerns, inquiries, and complaints from the member, the member's family, or the member's provider.

2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including CHOICES referrals from all sources, monitoring of calls via recording or other means, and compliance with standards.

2.18.1.3 The member services information line shall handle calls from callers with Limited English Proficiency as well as calls from members who are hearing impaired.

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

2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls

from members and to facilitate transfer of calls to a care coordinator from or on behalf of a CHOICES member that require immediate attention by a care coordinator. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section 2.18.1.

2.18.1.6 The CONTRACTOR shall ensure that all calls from CHOICES members to the nurse triage/nurse advice line that require immediate attention are immediately addressed or transferred to a care coordinator. During normal business hours, the transfer shall be a "warm transfer" (see definition in Section 1). After normal business hours, if the CONTRACTOR cannot transfer the call as a "warm transfer", the CONTRACTOR shall ensure that a care coordinator is notified and returns the member's call within thirty (30) minutes and that the care coordinator has access to the necessary information (e.g., the member's back-up plan) to resolve member issues. The CONTRACTOR shall implement protocols, prior approved by TENNCARE, that describe how calls to the nurse triage/nurse advice line from CHOICES members will be handled.

2.18.1.7 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, TENNderCare, and the CONTRACTOR's provider network.

2.18.1.8 The CONTRACTOR shall implement protocols, prior approved by TENNCARE, to ensure that calls to the member services information line that should be transferred/referred to other CONTRACTOR staff, including but not limited to a member services supervisor or a care coordinator, or to an external entity, including but not limited to the FEA, are transferred/referred appropriately.

2.18.1.9 The CONTRACTOR shall ensure that calls received during normal business hours that require immediate attention by a care coordinator are immediately transferred to a care coordinator as a "warm transfer"; that calls received after normal business hours that require immediate attention by a care coordinator are transferred to a care coordinator in accordance with Section 2.18.1.6; that calls for a member's care coordinator or care coordination team during normal business hours are handled in accordance with Section 2.9.6.11.7; that calls transferred to the FEA during business hours are "warm transfers"; that calls to other CONTRACTOR staff, at a minimum, occur without the caller having to disconnect or place a second call; and that messages to care coordinators and other CONTRACTOR are returned by the next business day.

2.18.1.10 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.1.11 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.1.12 Performance Standards for Member Services Line/Queue

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

2.18.1.12.2 The CONTRACTOR shall submit the reports required in Section 2.30.12 of this Agreement.

2.18.2 **Interpreter and Translation Services**

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

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

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

2.18.3 **Cultural Competency**

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

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

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

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

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

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

2.18.4.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in Section 2.14 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, TENNderCare, prior authorization and referral requirements, care coordination, and the CONTRACTOR's provider network. For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall maintain a dedicated queue to assist long-term care providers with enrollment, service authorization, or reimbursement questions or issues. Such period may be extended as determined necessary by TENNCARE.

2.18.4.7 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR shall have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 nurse triage line described in Section 2.18.1.5 of this Agreement for this purpose or may use another line the CONTRACTOR designates. The CONTRACTOR shall submit a description of how it will meet the requirements regarding its 24/7 ED assistance line, which shall provide the telephone number that will be used for hospitals requiring scheduling assistance and describe the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line. The CONTRACTOR shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting in accordance with Section 2.30.12.1.3.

2.18.4.8 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.9 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.4.10 <u>Performance Standards for Provider Service Line</u>

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

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

2.18.5 **Provider Handbook**

2.18.5.1 The CONTRACTOR shall issue a provider handbook to all contract providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

2.18.5.2 The CONTRACTOR shall develop a supplement for the provider handbook regarding CHOICES. This supplement shall include the information in Section 2.18.5.3 relating to the CHOICES program, as determined by TENNCARE, and the supplement shall be prior approved by TENNCARE and TDCI. The CONTRACTOR shall distribute the supplement to all contract providers no later than the end of the quarter prior to implementation of CHOICES. The CONTRACTOR shall distribute the supplement until the provider handbook is revised to include the CHOICES program, which shall be no later than the date specified by TENNCARE.

2.18.5.3 At a minimum the provider handbook shall include the following information:

2.18.5.3.1 Description of the TennCare program;

2.18.5.3.2 Covered services;

2.18.5.3.3 Description of the CHOICES program including but not limited to who qualifies for CHOICES (including the three CHOICES groups and enrollment targets for CHOICES Groups 2 and 3); how to enroll in CHOICES; long-term care services available to each CHOICES Group (including benefit limits, cost neutrality cap for members in Group 2, and the expenditure cap for members in Group 3); consumer direction of HCBS; self-direction of health care tasks; the level of care assessment and reassessment process; the needs assessment and reassessment processes; requirement to provide services in accordance with an approved plan of care including the amount, frequency, duration and scope of each service in accordance with the member's service schedule; service authorization requirements and processes; the role of the care coordinator; the role and responsibilities of long-term care and other providers; requirements regarding the electronic visit verification system and the provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff; how to submit clean claims; and documentation requirements for HCBS providers;

2.18.5.3.4 Emergency service responsibilities;

2.18.5.3.5 TENNderCare services and standards;

2.18.5.3.6 Information on members' appeal rights and complaint processes;

2.18.5.3.7 Policies and procedures of the provider complaint system;

2.18.5.3.8 Medical necessity standards and clinical practice guidelines;

2.18.5.3.9 PCP responsibilities;

2.18.5.3.10 Coordination with other TennCare contractors or MCO subcontractors;

2.18.5.3.11 Requirements regarding background checks;

2.18.5.3.12 Information on identifying and reporting suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq*.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.), including reporting to APS, CPS, and the CONTRACTOR;

2.18.5.3.13 Requirements for HCBS providers regarding critical incident reporting and management (see Section 2.15.8);

2.18.5.3.14 Requirements for nursing facility providers regarding patient liability (see Sections 2.6.7 and 2.21.5), including the collection of patient liability and the provider's ability, if certain conditions are met (including providing notice and required documentation to the CONTRACTOR and notice to the member), to refuse to provide services if the member does not pay his/her patient liability, as well as the additional potential consequences to the member of non-payment of patient liability, including disenrollment from CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

2.18.5.3.15 Requirement to notify the CONTRACTOR of significant changes in a CHOICES member's condition or care, hospitalizations, or recommendations for additional services (see Section 2.12.9.3.7);

2.18.5.3.16 Prior authorization, referral and other utilization management requirements and procedures;

2.18.5.3.17 Protocol for encounter data element reporting/records;

2.18.5.3.18 Medical records standard;

2.18.5.3.19 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

2.18.5.3.20 Payment policies;

2.18.5.3.21 Member rights and responsibilities;

2.18.5.3.22 Important phone numbers of all departments/staff a contract provider may need to reach at the CONTRACTOR's MCO; and

2.18.5.3.23 How to reach the contract provider's assigned provider relations representative.

2.18.5.4 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

2.18.6 **Provider Education and Training**

2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Agreement.

2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations

2.18.6.3 The CONTRACTOR shall conduct initial education and training for long-term care providers regarding the CHOICES program no later than thirty (30) days prior to implementation of CHOICES in the Grand Region covered by this Agreement. This education and training shall include but not be limited to:

2.18.6.3.1 An overview of the CHOICES program;

2.18.6.3.2 The three CHOICES groups and the enrollment targets for each (as applicable);

2.18.6.3.3 The long-term care services available to each CHOICES group (including benefit limits, cost neutrality cap for CHOICES Group 2, and the expenditure cap for CHOICES Group 3);

2.18.6.3.4 The level of care assessment and reassessment processes;

2.18.6.3.5 The needs assessment and reassessment processes;

2.18.6.3.6 The CHOICES intake process;

2.18.6.3.7 Service authorization requirements and processes;

2.18.6.3.8 The role and responsibilities of the care coordinator for members in CHOICES Group 1;

2.18.6.3.9 The role and responsibilities of the care coordinator for members in CHOICES Groups 2 and 3;

2.18.6.3.10 Requirement to provide services in accordance with an approved plan of care including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;

2.18.6.3.11 The role and responsibilities of long-term care and other providers;

2.18.6.3.12 Requirements regarding the electronic visit verification system and the provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff;

2.18.6.3.13 How to submit clean claims;

2.18.6.3.14 Background check requirements;

2.18.6.3.15 Information about abuse/neglect (which includes abuse, neglect and exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children), including how to assess risk for abuse/neglect, how to identify abuse/neglect, and how to report abuse/neglect to APS and the CONTRACTOR;

2.18.6.3.16 Critical incident reporting and management for HCBS providers;

2.18.6.3.17 The member complaint and appeal processes; and

2.18.6.3.18 The provider complaint system.

2.18.6.4 The CONTRACTOR shall provide training and education to long-term care providers regarding the CONTRACTOR's enrollment and credentialing requirements and processes (see Section 2.11.8).

2.18.6.5 For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall conduct monthly education and training for long-term care providers regarding claims submission and payment processes, which shall include but not be limited to an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by TENNCARE.

2.18.6.6 For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall conduct monthly education and training for HCBS providers regarding the use of the EVV system. Such period may be extended as determined necessary by TENNCARE.

2.18.6.7 The CONTRACTOR shall provide education and training on documentation requirements for HCBS.

2.18.6.8 The CONTRACTOR shall conduct ongoing provider education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement.

2.18.6.9 The CONTRACTOR shall inform all contract PCPs, specialists, and hospitals about the CHOICES program, using a notice developed by TENNCARE, no later than the end of the calendar quarter prior to implementation of the CHOICES program in the Grand Region covered by this Agreement.

2.18.6.10 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.

2.18.6.11 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. At least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that

provide evidence of compliance with the requirement in this Section 2.18.6.5, including when and how contact is made for each contract provider.

2.18.7 **Provider Relations**

2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to provide ongoing troubleshooting and education for contract providers.

2.18.7.2 The CONTRACTOR shall provide one-on-one assistance to long-term care providers as needed to help long-term care providers submit clean and accurate claims and minimize claim denial. The CONTRACTOR shall develop and implement protocols, prior approved by TENNCARE, that specify the CONTRACTOR's criteria for providing one-on-one assistance to a provider and the type of assistance the CONTRACTOR will provide. At a minimum, the CONTRACTOR shall contact a provider if, during the first year after implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR has or will deny ten percent (10%) or more of the total value of the provider's claims for a rolling thirty (30) day period, and shall, in addition to issuing a remittance advice, contact the provider to review each of the error(s)/reason(s) for denial and advise how the provider can correct the error for resubmission (as applicable) and avoid the error/reason for denial in the future.

2.18.7.3 The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Agreement.

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. The survey shall be structured so that long-term care provider satisfaction results, behavioral health provider satisfaction results, and physical health provider satisfaction results can be separately stratified.

2.18.8 **Provider Complaint System**

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

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-126(b) (see Section 2.22.5.2).

2.18.9 **FEA Education and Training**

2.18.9.1 The CONTRACTOR shall provide education and training to the FEA and its staff regarding key requirements of this Agreement and the subcontract between the CONTRACTOR and the FEA.

2.18.9.2 The CONTRACTOR shall conduct initial education and training to the FEA and its staff at least thirty (30) days prior to implementation of CHOICES in the Grand Region covered by this Agreement. This education and training shall include but not be limited to:

2.18.9.2.1 The roles and responsibilities of the CONTRACTOR and the FEA in implementing and monitoring consumer direction of HCBS;

2.18.9.2.2 The FEA's responsibilities for communicating with the CONTRACTOR, members and workers;

2.18.9.2.3 Customer service requirements;

2.18.9.2.4 Requirements and processes regarding referral to the FEA;

2.18.9.2.5 Requirements and processes, including timeframes, for authorization of consumer-directed HCBS;

2.18.9.2.6 Requirements and processes, including timeframes, for claims submission and payment;

2.18.9.2.7 Systems requirements and information exchange requirements;

2.18.9.2.8 Requirements regarding the electronic visit verification system;

2.18.9.2.9 Requirements and role and responsibility regarding abuse and neglect plan protocols (see Section 2.24.4.3) and critical incident reporting and management (see Section 2.15.8); and

2.18.9.2.10 The CONTRACTOR's member complaint and appeal processes.

2.18.9.3 The CONTRACTOR shall conduct ongoing FEA education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement and the subcontract between the CONTRACTOR and the FEA.

2.18.10 **Member Involvement with Behavioral Health Services**

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

2.18.10.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed

representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

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

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

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

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

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

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

19. Section 2.19 shall be deleted in its entirety and replaced with the following:

2.19 COMPLAINTS AND APPEALS

2.19.1 General

2.19.1.1 Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider or consumer-directed worker with the member's written consent. Complaint shall mean a written or verbal expression of dissatisfaction about an action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. Examples of complaints include but are not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness

of a provider or employee. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2.17.4. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

2.19.1.2 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2.15.2, to the review of member complaints and appeals that have been received.

2.19.1.3 The CONTRACTOR shall ensure that punitive action is not taken against a provider or worker who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2.19.2 **Complaints**

2.19.2.1 The CONTRACTOR's complaint process shall, at a minimum, meet the requirements outlined herein.

2.19.2.2 The CONTRACTOR's complaint process shall only be for complaints, as defined in Sections 1 and 2.19.1.1 of this Agreement. The CONTRACTOR shall ensure that all appeals, as defined in Sections 1 and 2.19.1.1, are addressed through the appeals process specified in Section 2.19.3 below.

2.19.2.3 The CONTRACTOR shall allow a member to file a complaint either orally or in writing at any time.

2.19.2.4 Within five (5) business days of receipt of the complaint, the CONTRACTOR shall provide written notice to the member that the complaint has been received and the expected date of resolution. However, if the CONTRACTOR resolved the complaint and verbally informed the member of the resolution within five (5) business days of receipt of the complaint, the CONTRACTOR shall not be required to provide written acknowledgement of the complaint.

2.19.2.5 The CONTRACTOR shall resolve and notify the member in writing of the resolution of each complaint as expeditiously as possible but no later than thirty (30) days from the date the complaint is received by the CONTRACTOR. The notice shall include the resolution and the basis for the resolution. However, if the CONTRACTOR resolved the complaint and verbally informed the member of the resolution within five (5) business days of receipt of the complaint, the CONTRACTOR shall not be required to provide written notice of resolution.

2.19.2.6 The CONTRACTOR shall assist members with the complaint process, including but not limited to completing forms.

2.19.2.7 The CONTRACTOR shall track and trend all complaints, timeframes and resolutions and ensure remediation of individual and/or systemic issues.

2.19.2.8 The CONTRACTOR shall submit reports regarding member complaints as specified in Section 2.30.13.

2.19.3 **Appeals**

2.19.3.1 The CONTRACTOR's appeal process shall, at a minimum, meet the requirements outlined herein.

2.19.3.2 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2.19.3.3 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

2.19.3.4 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action shall be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

2.19.3.5 The CONTRACTOR shall identify the appropriate individual or body within the CONTRACTOR's MCO having decision-making authority as part of the appeal procedure.

2.19.3.6 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

2.19.3.7 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2.19.3.8 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2.19.3.9 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the member and TENNCARE.

2.19.3.10 The CONTRACTOR shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.

2.19.3.11 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.

2.19.3.12 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.19.3.13 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

2.19.3.14 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.

2.19.3.15 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.

2.19.3.16 The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2.24.6 and 2.14.8.

2.19.3.17 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.19.3.18 Except for long-term care eligibility and enrollment appeals, which are handled by TENNCARE, member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to the Department of Human Services.

20. Section 2.21 shall be deleted in its entirety and replaced with the following:

2.21 FINANCIAL MANAGEMENT

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

2.21.1 **Payments by TENNCARE**

The CONTRACTOR shall accept payments remitted by TENNCARE in accordance with Section 3 as payment in full for all services required pursuant to this Agreement.

2.21.2 **Savings/Loss**

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

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

2.21.3 **Interest**

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

2.21.4 **Third Party Liability Resources**

2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party. The CONTRACTOR shall develop and implement policies and procedures to meet its obligations regarding third party liability when the third party (e.g., long-term care insurance) pays a cash benefit to the member, regardless of services used or does not allow the member to assign his/her benefits.

2.21.4.1.1 If third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

2.21.4.1.2 If TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.

2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for one of these services:

2.21.4.1.3.1 TENNderCare;

2.21.4.1.3.2 Prenatal or preventive pediatric care; or

2.21.4.1.3.3 All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.

2.21.4.1.4 The claims specified in Sections 2.21.4.1.3.1, 2.21.4.1.3.2, and 2.21.4.1.3.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.

2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2.21.4 of this Agreement.

2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee.

2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for the purposes of reporting.

2.21.4.6 The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation claims. This editing should, at minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'

2.21.4.7 TennCare cost sharing and patient liability responsibilities permitted pursuant to Sections 2.6.7 and 2.21.5 of this Agreement shall not be considered TPL.

2.21.4.8 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.

2.21.4.9 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.

2.21.4.10 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.

2.21.4.11 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.

2.21.4.12 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries.

TENNCARE shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.21.4.13 TENNCARE shall be solely responsible for estate recovery activities and shall retain any and all funds recovered thorough these activities.

2.21.5 **Patient Liability**

2.21.5.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for members via the eligibility/enrollment file.

2.21.5.2 The CONTRACTOR shall delegate collection of patient liability to the nursing facility and shall pay the facility net of the applicable patient liability amount.

2.21.6 **Solvency Requirements**

2.21.6.1 Minimum Net Worth

2.21.6.1.1 Until the CONTRACTOR has provided services under this Agreement for a full calendar year, the CONTRACTOR shall establish and maintain a minimum net worth equal to the greater of:

2.21.6.1.1.1 One million five hundred thousand dollars ($1,500,000); or

2.21.6.1.1.2 An amount totaling four percent (4%) of the first one hundred fifty million dollars ($150,000,000) of the CONTRACTOR's TennCare revenue which shall be calculated by: totaling the weighted average capitation rate, as determined by TENNCARE by multiplying the base capitation rates originally proposed by the CONTRACTOR and the priority add-on rates effective on the start date of operations specified by the State by the number of enrollees (for the appropriate rate cell) assigned to the CONTRACTOR thirty (30) calendar days prior to the start date of operations for enrollment effective on the start date of operations.

2.21.6.1.2 In the event that actual enrollment as of sixty (60) days after the start date of operations increased or decreased by more than ten percent (10%) over enrollment as of thirty (30) calendar days prior to the start date of operations, the minimum net worth requirement specified in Section 2.21.6.1.1 shall be recalculated to reflect actual enrollment as of sixty (60) calendar days after the start date of operations.

2.21.6.1.3 After the CONTRACTOR has provided services under this Agreement for a full calendar year, the CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-112.

2.21.6.1.4 Any and all payments made by TENNCARE, including capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-112.

2.21.6.1.5 The CONTRACTOR shall demonstrate evidence of its compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR. The CONTRACTOR agrees that failure to maintain any of the financial requirements in accordance with this Section 2.21.6.1 through 2.21.6.7, as determined by TDCI, shall constitute hazardous financial conditions as defined by TCA 56-32-112.

2.21.6.2 Statutory Net Worth for Enhanced Enrollment

In the event of a significant enrollment expansion as defined in TCA 56-32-103(c)(2):

2.21.6.2.1 The CONTRACTOR agrees that in order to maintain the minimum net worth requirements described in Section 2.21.6.1, the minimum net worth requirements are to be recalculated.

2.21.6.2.2 The calculation of minimum net worth shall be based upon annual projected premiums including the estimated premiums for the additional enrollment versus the prior year actual premium revenue. Estimated premiums will be based on the capitation payment rates in effect at the time of the calculation and projected future enrollment. The formula set forth in TCA 56-32-112(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement.

2.21.6.2.3 The CONTRACTOR shall demonstrate to the satisfaction of TDCI that this enhanced minimum net worth balance has been established prior to the assignment of additional enrollees to the CONTRACTOR by TENNCARE.

2.21.6.2.4 The CONTRACTOR shall maintain the greater of the enhanced minimum net worth balance or the minimum net worth balance calculated pursuant to TCA 56-32-112, until the CONTRACTOR has completed a full calendar year with the significantly expanded enrollment.

2.21.6.3 Statutory Net Worth for CHOICES Implementation

2.21.6.3.1 The CONTRACTOR agrees that in order to maintain the minimum net worth requirements described in Section 2.21.6.1, the minimum net worth requirements are to be recalculated for the implementation of CHOICES in the Grand Region covered by this Agreement.

2.21.6.3.2 The calculation of minimum net worth shall be based upon annual projected premiums versus the prior year actual premium revenue. Estimated premiums shall be based on the capitation payment rates for CHOICES and non-CHOICES members to be in effect upon implementation of CHOICES and projected enrollment as of the date of CHOICES implementation in the Grand Region covered by this Agreement. The formula set forth in TCA 56-32-112(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement.

2.21.6.3.3 The CONTRACTOR shall demonstrate to the satisfaction of TDCI that this enhanced minimum net worth balance has been established prior to the implementation of CHOICES in the Grand Region covered by this Agreement.

2.21.6.3.4 The CONTRACTOR shall maintain the greater of the enhanced minimum net worth balance or the minimum net worth balance calculated pursuant to TCA 56-32-112, until the CONTRACTOR has completed a full calendar year with CHOICES.

2.21.6.3.5 After the CONTRACTOR has provided services under CHOICES for a full calendar year, the CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-112.

2.21.6.4 Restricted Deposits

The CONTRACTOR shall achieve and maintain restricted deposits in an amount equal to the net worth requirement specified in Section 2.21.6.1. TDCI shall calculate the amount of restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement.

2.21.6.5 Restricted Deposits for Enhanced Enrollment or CHOICES Implementation

In the event of an increase in the CONTRACTOR's statutory net worth requirement as a result of a significant enrollment expansion as defined in TCA 56-32-103(c)(2) or the implementation of CHOICES, the CONTRACTOR shall increase its restricted deposit to equal its enhanced minimum net worth requirement required by Section 2.21.6.2 or Section 2.21.6.3, as applicable. TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement. The CONTRACTOR shall demonstrate to the satisfaction of TDCI that the CONTRACTOR has increased its restricted deposit in accordance with this Section prior to the assignment of additional enrollees to the CONTRACTOR by TENNCARE.

2.21.6.6 Liquidity Ratio Requirement

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

2.21.6.7 If the CONTRACTOR fails to meet the applicable net worth and/or restricted deposit requirement, said failure shall constitute a hazardous financial condition and the CONTRACTOR shall be considered to be in breach of the terms of the Agreement.

2.21.7 **Accounting Requirements**

2.21.7.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system

shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.

2.21.7.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in this Agreement.

2.21.8 **Insurance**

2.21.8.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Agreement. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.

2.21.8.2 Except as otherwise provided in Section 2.12 or in the model subcontract with the FEA (see Section 2.26.6), the CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.

2.21.8.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.

2.21.8.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.

2.21.8.5 Failure to provide proof of adequate coverage within the specified time period may result in this Agreement being terminated.

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. This disclosure shall be made in accordance with the requirements in Section 2.30.15.3.2. The following information shall be disclosed:

2.21.9.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent,

child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

2.21.9.2 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;

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

2.21.9.5 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:

2.21.9.5.1 The CONTRACTOR shall disclose the following transactions:

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

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

2.21.9.5.1.3 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.

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

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

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

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

2.21.9.5.2.4 Justification of the reasonableness of each transaction.

2.21.9.5.3 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.

2.21.9.5.4 A party in interest is:

2.21.9.5.4.1 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;

2.21.9.5.4.2 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;

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

2.21.9.5.4.4 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

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

2.21.10 **Internal Audit Function**

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

2.21.11 **Audit of Business Transactions**

2.21.11.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the requirements in Section 2.30.15.4.3 of this Agreement.

2.21.11.2 No later than December 1 of each year, the CONTRACTOR shall submit a copy of the full executed agreement to audit accounts to TENNCARE. Such agreement shall include the following language:

2.21.11.2.1 The auditor agrees to retain working papers for no less than five (5) years and that all audit working papers shall, upon request, be made available for review by the Comptroller of the Treasury, the Comptroller's representatives, agents, and legal counsel, or the TennCare Division of the Tennessee Department of Commerce and Insurance, during normal working hours while the audit is in progress and/or subsequent to the completion of the report. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section 2.23.2 (Data and Document Management Requirements), 2.23.3 (System and Data Integration Requirements), or 2.23.6 (Security and Access Management Requirements) of this Agreement.

2.21.11.2.2 Any evidence of fraud, such as defalcation, misappropriation, misfeasance, malfeasance, embezzlement, fraud or other illegal acts shall be reported by the auditor, in writing immediately upon discovery, to the Comptroller of the Treasury, State of Tennessee, who shall under all circumstances have the authority, at the discretion of the Comptroller, to directly investigate such matters. If the circumstances disclosed by the audit call for a more detailed investigation by the auditor than necessary under ordinary circumstances, the auditor shall inform the organization's governing body in writing of the need for such additional investigation and the additional compensation required therefore. Upon approval by the Comptroller of the Treasury, an amendment to this contract may be made by the organization's governing body and the auditor for such additional investigation.

21. Section 2.22 shall be deleted in its entirety and replaced with the following:

2.22 CLAIMS MANAGEMENT

2.22.1 **General**

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

2.22.2 **Claims Management System Capabilities**

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service, date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track and report service use against benefit limits in accordance with a methodology set by TENNCARE.

2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that can handle online submission of individual claims by long-term care providers as well as accept and process batches of claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). The online claims submission capability for long-term care providers shall be accessible via the World Wide Web or through an alternate, functionally equivalent medium.

2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section 2.23 of this Agreement.

2.22.2.4 As part of the ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.

2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.22.2.6 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

2.22.3 **Paper Based Claims Formats**

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

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450/UB04
Dental	ADA

2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.

2.22.3.3 For the forms identified in Section 2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.

2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

2.22.4 **Prompt Payment**

2.22.4.1 The CONTRACTOR shall comply with prompt pay claims processing requirements in accordance with TCA 56-32-126.

2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.

2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all claims for covered services delivered to a TennCare enrollee. The terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-126(b)(1)(A) and (B).

2.22.4.4 Notwithstanding Sections 2.22.4.1 through 2.22.4.3, the CONTRACTOR shall comply with the following processing requirements for nursing facility claims and for HCBS claims for services other than PERS, assistive technology, minor home modifications, and pest control submitted electronically in a HIPAA-compliant format:

2.22.4.4.1 Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within fourteen (14) calendar days of receipt.

2.22.4.4.2 Ninety-nine point five percent (99.5%) of clean claims for nursing facility and HCBS other than PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt.

2.22.4.5 The CONTRACTOR shall comply with the requirements in Sections 2.22.4.2 and 2.22.4.3 above for processing claims for PERS, assistive technology, minor home modifications, and pest control.

2.22.4.6 The CONTRACTOR shall provide claims information and supporting claims documentation as specified by TENNCARE or TDCI in order for TENNCARE and/or TDCI to verify the CONTRACTOR's compliance with prompt payment requirements.

2.22.4.7 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

2.22.4.8 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to

compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.

2.22.4.9 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR's MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment.

2.22.4.10 As it relates to MCO Assignment Unknown (see Sections 2.13.10 and 2.13.11), the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.22.5 **Claims Dispute Management**

2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved in writing by TENNCARE prior to its implementation.

2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-126.

2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

2.22.6 **Claims Payment Accuracy – Minimum Audit Procedures**

2.22.6.1 On a monthly basis the CONTRACTOR shall submit claims payment accuracy percentage reports (see Section 2.30.16.1).

2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section 2.21.10 of this Agreement.

2.22.6.3 The audit shall utilize a random sample of all "processed or paid" claims upon initial submission in each month (the terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-126(b)(1)(A) and (B)). A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with HCBS provided to CHOICES members.

2.22.6.4 The minimum attributes to be tested for each claim selected shall include:

2.22.6.4.1 Claim data correctly entered into the claims processing system;

2.22.6.4.2 Claim is associated to the correct provider, or if submitted by the FEA, the correct consumer-directed worker;

2.22.6.4.3 Service obtained the proper authorization;

2.22.6.4.4 Member eligibility at processing date correctly applied;

2.22.6.4.5 Allowed payment amount agrees with contracted rate;

2.22.6.4.6 Duplicate payment of the same claim has not occurred;

2.22.6.4.7 Denial reason applied appropriately;

2.22.6.4.8 Copayment application considered and applied;

2.22.6.4.9 Patient liability correctly identified and applied;

2.22.6.4.10 Effect of modifier codes correctly applied;

2.22.6.4.11 Other insurance, including long-term care insurance, properly considered and applied;

2.22.6.4.12 Application of benefit limits;

2.22.6.4.13 Whether the processing of the claim correctly considered whether services that exceeded a benefit limit for HCBS were provided as a cost effective alternative;

2.22.6.4.14 Application of the cost neutrality cap for a CHOICES member in Group 2;

2.22.6.4.15 Application of the expenditure cap for a CHOICES member in Group 3; and

2.22.6.4.16 Proper coding including bundling/unbundling.

2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:

2.22.6.5.1 Results for each attribute tested for each claim selected;

2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;

2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;

2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and

2.22.6.5.5 Claims processed or paid in error have been corrected.

2.22.6.6 If the CONTRACTOR subcontracts for the provision of any covered services (see Section 2.26), and the subcontractor is responsible for processing claims (see Section 2.26.12), then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report shall be based on an audit conducted in compliance with the requirements of this Section 2.22.6.

2.22.7 **Claims Processing Methodology Requirements**

2.22.7.1 The CONTRACTOR shall perform front end system edits, including but not limited to:

2.22.7.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

2.22.7.1.2 Third party liability (TPL);

2.22.7.1.3 Medical necessity (e.g., appropriate age/sex for procedure);

2.22.7.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;

2.22.7.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;

2.22.7.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;

2.22.7.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted; and

2.22.7.1.8 Benefit limits: the system shall ensure that benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid and whether HCBS that exceed a benefit limit were approved as a cost effective alternative.

2.22.7.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., date of discharge is later than date of admission; admission or discharge dates are not in the future or outside of a member's TennCare eligibility span.

2.22.7.3 The CONTRACTOR shall ensure that the cost neutrality cap or expenditure cap applicable to a particular CHOICES member is not exceeded.

2.22.7.4 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary and were provided in accordance with state and federal requirements. This shall include, as applicable, review of provider documentation.

2.22.7.5 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

2.22.8 **Explanation of Benefits (EOBs) and Related Functions**

2.22.8.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.

2.22.8.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.

2.22.8.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall include: claims for services with benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

2.22.8.4 On a monthly basis, the CONTRACTOR shall sample a minimum of one hundred (100) claims and associated EOBs. The sample shall be based on a minimum of twenty-five (25) claims per check run. The EOBs shall be examined for correctness based on how the associated claim was processed and for adherence to the requirements outlined in Section 2.22.8. The CONTRACTOR shall ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types. To the extent that the CONTRACTOR and/or TENNCARE considers a particular type of service or provider to warrant closer scrutiny, the CONTRACTOR shall over sample as needed.

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

2.22.9 **Remittance Advices and Related Functions**

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

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

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

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

2.22.10 **Processing of Payment Errors**

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

2.22.11 **Notification to Providers**

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

2.22.12 **Payment Cycle**

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

2.22.13 **Excluded Providers**

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

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

22. Section 2.24 shall be deleted in its entirety and replaced with the following:

2.24 ADMINISTRATIVE REQUIREMENTS

2.24.1 **General Responsibilities**

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

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

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

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

2.24.1.5 As provided in Section 4.10 of this Agreement, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

2.24.2 **Behavioral Health Advisory Committee**

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

2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include families of adults with serious and/or persistent mental illness (SPMI) and families of children with serious emotional disturbance (SED);

2.24.2.2 There shall be geographic diversity;

2.24.2.3 There shall be cultural and racial diversity;

2.24.2.4 There shall be representation by providers and consumers (or family members of consumers) of substance abuse services;

2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee shall have input into policy development, planning for services, service evaluation, and member, family member and provider education;

2.24.2.6 Meetings shall be held at least quarterly;

2.24.2.7 Travel costs shall be paid by the CONTRACTOR;

2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.18.1; and

2.24.2.9 The CONTRACTOR, as membership changes, shall submit current membership lists to the State.

2.24.3 **CHOICES Advisory Group**

2.24.3.1 To promote a collaborative effort to enhance the long-term care service delivery system in the Grand Region covered by this Agreement while maintaining a member-centered focus, the CONTRACTOR shall establish a CHOICES advisory group that is accountable to the CONTRACTOR's governing body to provide input and advice regarding the CONTRACTOR's CHOICES program and policies.

2.24.3.2 The CONTRACTOR's CHOICES advisory group shall include CHOICES members, member's representatives, advocates, and providers. At least fifty-one percent (51%) of the group shall be CHOICES members and/or their representatives (e.g., family members or caregivers). The advisory group shall include representatives from nursing facility and HCBS providers, including community-based residential alternative providers. The group shall reflect the geographic, cultural and racial diversity of the Grand Region covered by this Agreement.

2.24.3.3 At a minimum, the CONTRACTOR's CHOICES advisory group shall have input into the CONTRACTOR's planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family and provider education.

2.24.3.4 The CONTRACTOR shall provide an orientation and ongoing training for advisory group members so they have sufficient information and understanding of the CHOICES program to fulfill their responsibilities.

2.24.3.5 The CONTRACTOR's CHOICES advisory group shall meet at least quarterly, and the CONTRACTOR shall keep a written record of meetings.

2.24.3.6 The CONTRACTOR shall pay travel costs for advisory group members who are CHOICES members or their representatives.

2.24.3.7 The CONTRACTOR shall report on the activities of the CONTRACTOR's CHOICES advisory group as required in Section 2.30.18.2.

2.24.3.8 As advisory group membership changes, the CONTRACTOR shall submit current membership lists to TENNCARE.

2.24.4 **Abuse and Neglect Plan**

2.24.4.1 The CONTRACTOR shall develop and implement an abuse and neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of CHOICES members who are adults (see TCA 71-6-101 *et seq*.) and suspected brutality, abuse, or neglect of CHOICES members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.); a plan for educating and training providers, subcontractors, care coordinators, and other CONTRACTOR staff regarding the protocols; and a plan for training members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect.

2.24.4.2 The CONTRACTOR's abuse and neglect protocols shall include, but not be limited to the following:

2.24.4.2.1 Protocols for assessing risk for abuse and/or neglect, including factors that may indicate the potential for abuse and/or neglect;

2.24.4.2.2 Protocols for reducing a member's risk of abuse and/or neglect (e.g., frequency of care coordinator home visits, referrals to non-covered support services);

2.24.4.2.3 Indicators for identifying suspected abuse and/or neglect;

2.24.4.2.4 Requirements for reporting suspected abuse and/or neglect, including reporting suspected abuse and/or neglect of a child pursuant to TCA 37-1-403, reporting suspected abuse and/or neglect of an adult to APS pursuant to TCA 71-6-103, and reporting suspected abuse and/or neglect to the CONTRACTOR pursuant to Section 2.15.8.4;

2.24.4.2.5 Steps for protecting a member if abuse and/or neglect is suspected (e.g., removing a staff person suspected of committing the abuse and/or neglect, making referrals for members to support services); and

2.24.4.2.6 Requirements regarding coordination and cooperation with APS/CPS investigations and remediations.

2.24.4.3 The CONTRACTOR's abuse and neglect plan shall also define the role and responsibilities of the fiscal employer agent (see definition in Section 1) in assessing and reducing a member's risk of abuse and neglect, identifying and reporting abuse and neglect, protecting a member if abuse and/or neglect is suspected; training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding the protocols identified in Sections 2.24.4.2.1 through 2.24.4.2.6 above; and training members and caregivers regarding identification and reporting of suspected abuse and/or neglect. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.24.4 as well as TENNCARE's contract with the fiscal employer agent and the model subcontract between the CONTRACTOR and the FEA.

2.24.5 **Performance Standards**

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

2.24.6 **Medical Records Requirements**

2.24.6.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records (as defined in Section 1) in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.

2.24.6.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:

2.24.6.2.1 Confidentiality of medical records;

2.24.6.2.2 Medical record documentation standards; and

2.24.6.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:

2.24.6.2.3.1 As applicable, medical records shall be maintained or available at the site where covered services are rendered;

2.24.6.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section 2.24.6.2.3.3 below) be given copies thereof upon request;

2.24.6.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and

2.24.6.2.3.4 Performance goals to assess the quality of medical record keeping.

2.24.6.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.

2.24.6.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

23. Section 2.25 shall be deleted in its entirety and replaced with the following:

2.25 MONITORING

2.25.1 General

2.25.1.1 TENNCARE, in its daily activities, shall monitor the CONTRACTOR for compliance with the provisions of this Agreement.

2.25.1.2 TENNCARE, CMS, or their representatives shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Monitoring activities shall include, but not be limited to, inspection of the CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. TENNCARE will emphasize

case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes.

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

2.25.2 **Facility Inspection**

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

2.25.3 **Inspection of Work Performed**

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

2.25.4 **Approval Process**

2.25.4.1 As specified by TENNCARE, TENNCARE must approve various deliverables/items before they can be implemented by the CONTRACTOR.

2.25.4.2 At any time that approval of TENNCARE is required in this Agreement, such approval shall not be considered granted unless TENNCARE issues its approval in writing.

2.25.4.3 TENNCARE shall specify the deliverables (see Attachment VIII) to be submitted to TENNCARE, whether they require prior approval or not, deliverable instructions, submission and approval time frames, and technical assistance as required.

2.25.4.4 Should TENNCARE not respond to a submission of a deliverable in the amount of time agreed to by TENNCARE, the CONTRACTOR shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or withholds shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the item if it is determined by TENNCARE to be in the best interest of the TennCare program.

2.25.5 **Availability of Records**

2.25.5.1 The CONTRACTOR shall ensure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Office of the Comptroller of the

Treasury personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Unit (TBI MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to TennCare enrollees.

2.25.5.2 The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. The CONTRACTOR shall send all records to be sent by mail to TENNCARE within twenty (20) business days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.

2.25.5.3 The CONTRACTOR and any of its subcontractors, providers or any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

2.25.5.4 The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

2.25.5.4.1 Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or subcontractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, TBI MFCU, DOJ and the

DHHS OIG, and the Office of the Comptroller of the Treasury and any duly authorized governmental agency, including federal agencies; and

2.25.5.4.2 Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

2.25.5.5 The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified person or organization to conduct the audits.

2.25.6 **Audit Requirements**

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

2.25.7 **Independent Review of the CONTRACTOR**

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

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

2.25.8 **Accessibility for Monitoring**

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

2.25.9 **CHOICES Consumer/Family Surveys**

2.25.9.1 The EQRO will administer an annual survey to a representative sample of CHOICES members to assess members' quality of life and members' and/or caregivers' satisfaction with the CHOICES program. The CONTRACTOR shall cooperate fully with the EQRO in conducting the survey. The EQRO will provide a copy of its findings to the CONTRACTOR.

2.25.9.2 As specified in Section 2.15.7, the CONTRACTOR shall administer the Health Outcomes Survey and submit survey data files to TENNCARE. The EQRO will test, clean, and score the data, develop reports, and provide relevant reports to the CONTRACTOR.

2.25.9.3 TENNCARE or its designee will conduct a post-transition survey of a representative sample of CHOICES members following discharge from a nursing facility to an HCBS delivery setting (including the member's home or community-based residential alternatives setting) to assess the quality of the care transition. The CONTRACTOR shall cooperate fully with TENNCARE or its designee in conducting these surveys. TENNCARE or its designee will provide a copy of its findings to the CONTRACTOR.

2.25.9.4 TENNCARE or its designee will conduct a survey of a representative sample of CHOICES members following the CONTRACTOR's needs assessment and care planning processes to assess members' and/or caregivers' satisfaction with these processes. The CONTRACTOR shall cooperate fully with TENNCARE or its designee in conducting the survey. TENNCARE or its designee will provide a copy of the survey findings to the CONTRACTOR.

2.25.10 **Monitoring Quality of Care for CHOICES**

In addition to any other monitoring activities conducted by TENNCARE, the CONTRACTOR shall cooperate fully with any monitoring activities conducted by TENNCARE regarding the CHOICES program. These activities will include but not be limited to the following:

2.25.10.1 Quarterly and annual monitoring to ensure that CHOICES members receive disease management interventions and the adequacy and appropriateness of these interventions (see Sections 2.30.5.3 through 2.30.5.5).

2.25.10.2 For the first six (6) months after implementation of CHOICES in the Grand Region covered by this Agreement, or as long as determined necessary by TENNCARE, monthly monitoring of the CONTRACTOR's performance regarding transitioning CHOICES members. TENNCARE will review the *Status of Transitioning CHOICES*

Members report submitted by the CONTRACTOR (see Section 2.30.6.2) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.3 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Agreement regarding timeframes for assessments, care planning, and implementation of services for members who are enrolled through the SPOE. TENNCARE will review the *New Member Assessment and Care Planning and Initiation of Services* reports submitted by the CONTRACTOR (see Section 2.30.6.3) to determine the CONTRACTOR's performance on specified measures. In the event the CONTRACTOR's performance on a measure is less than one hundred percent (100%), TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.4 Quarterly monitoring to determine the CONTRACTOR's adherence to the timelines in this Agreement regarding CHOICES intake of members who may be eligible for CHOICES. TENNCARE will review the *CHOICES Intake, Enrollment and Service Initiation* reports submitted by the CONTRACTOR (see Section 2.30.6.4) to determine the CONTRACTOR's performance on specified measures. In the event the CONTRACTOR's performance on a measure is less than one hundred percent (100%), TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.5 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Agreement regarding ongoing assessment and care planning and service initiation timeframes. TENNCARE will review the *Ongoing Assessment and Care Planning and Service Initiation* reports submitted by the CONTRACTOR (see Section 2.30.6.5) to determine the CONTRACTOR's performance on specified measures. In the event the CONTRACTOR's performance on a measure is less than one hundred percent (100%), TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.6 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Agreement regarding care coordinator contacts for CHOICES members following enrollment into CHOICES. TENNCARE will review the *Post-Enrollment Care Coordination Contact* reports submitted by the CONTRACTOR (see Section 2.30.6.6) to determine the CONTRACTOR's performance on specified measures. In the event the CONTRACTOR's performance on a measure is less than one hundred percent (100%), TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.7 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Agreement regarding processes for identifying, assessing, and transitioning CHOICES who may have the ability and/or desire to transition from a nursing facility to the community. TENNCARE will review the *Nursing Facility to Community Transition* reports submitted by the CONTRACTOR (see Section 2.30.6.8) to determine the CONTRACTOR's performance on specified measures. In the event the CONTRACTOR's performance on a measure is less than one hundred percent (100%), TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to prescribed requirements. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.8 Monthly monitoring regarding missed and late visits. TENNCARE will review the *HCBS Missed Visits* reports submitted by the CONTRACTOR (see Section 2.30.6.9) to determine the CONTRACTOR's performance on specified measures. TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.9 For CHOICES members identified by TENNCARE, monthly case reviews to monitor the objectivity of the CONTRACTOR's needs assessment and care planning processes and to ensure consistent and reliable outcomes.

2.25.10.10 Quarterly monitoring of the CONTRACTOR's provider network file (see Section2.30.7) to ensure that CHOICES provider network requirements are met (see Section 2.11.6).

2.25.10.11 Annual monitoring of the CONTRACTOR's long-term care provider network development plan to ensure that the CONTRACTOR is making sufficient progress towards meeting its network development and expansion goals (see Section 2.11.6.6).

TENNCARE will review the plan provided by the CONTRACTOR (see Section 2.30.7.6) and will evaluate the adequacy of the CONTRACTOR's long-term care network and the CONTRACTOR's efforts to improve the network where deficiencies exist.

2.25.10.12 Quarterly monitoring of critical incidents. TENNCARE will review the *Critical Incidents* reports submitted by the CONTRACTOR (see Section 2.30.11.7) to identify potential performance improvement activities and the adequacy of the CONTRACTOR's action steps to reduce the number of critical incidents and improve the critical incidents reporting and management process. TENNCARE may conduct a more in-depth review and/or request additional information.

2.25.10.13 Quarterly monitoring of the CONTRACTOR's member complaints process to determine compliance with timeframes prescribed in Section 2.19.2 of this Agreement and appropriateness of resolutions. TENNCARE will review the *Member Complaints* reports submitted by the CONTRACTOR (see Section 2.30.13), to determine the CONTRACTOR's performance on specified measures. In the event the CONTRACTOR's performance on a measure is less than one hundred percent (100%), TENNCARE will evaluate the adequacy and appropriateness of the CONTRACTOR's remediation and improvement activities. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a performance improvement plan, a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.14 Review of all reports from the CONTRACTOR (see Section 2.30) and any related follow-up activities.

2.25.11 **Corrective Action Requirements**

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

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

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

24. Section 2.26 shall be deleted in its entirety and replaced with the following:

2.26 SUBCONTRACTS

2.26.1 Subcontract Relationships and Delegation

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

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

2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

2.26.1.3 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;

2.26.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and

2.26.1.5 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2.12 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

2.26.2 Legal Responsibility

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

2.26.3 Prior Approval

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

CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 1.

2.26.4 **Subcontracts for Behavioral Health Services**

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

2.26.5 **Subcontracts for Assessments and Plans of Care**

If the CONTRACTOR subcontracts with an entity to conduct level of care or needs assessments or reassessments and/or develop or authorize plans of care (see Section 2.9.6), such subcontractor shall not provide any direct long-term care services.

2.26.6 **Subcontract with Fiscal Employer Agent (FEA)**

As required in Section 2.9.7.3, the CONTRACTOR shall contract with TENNCARE's designated FEA to provide assistance to members choosing consumer direction of HCBS. This subcontract shall include the provisions specified by TENNCARE in the model FEA subcontract provided to the CONTRACTOR. The CONTRACTOR shall not be liable for any failure, error, or omission by the FEA related to the FEA's verification of worker qualifications.

2.26.7 **Standards**

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Agreement. This includes, but is not limited to, Sections 2.19, 2.21.7, 2.25.5, 2.25.6, 2.25.8, 2.25.9, 4.3, 4.19, 4.31, and 4.32 of this Agreement.

2.26.8 **Quality of Care**

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

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

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

2.26.10 **Children in State Custody**

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

2.26.11 **Assignability**

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

2.26.12 **Claims Processing**

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, transportation, or consumer-directed HCBS if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.12.2 As required in Section 2.30.19 of this Agreement, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations.

2.26.13 **HIPAA Requirements**

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

2.26.14 **Compensation for Utilization Management Activities**

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

2.26.15 **Notice of Subcontractor Termination**

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

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

25. Section 2.29 shall be deleted in its entirety and replaced with the following:

2.29 PERSONNEL REQUIREMENTS

2.29.1 Staffing Requirements

2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Agreement.

2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. In the event of a change to any of the key staff identified in Section 2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change.

2.29.1.3 The minimum key staff requirements are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person.

2.29.1.3.1 A full-time administrator/project director dedicated to the TennCare program who has clear authority over the general administration and day-to-day business activities of this Agreement;

2.29.1.3.2 [Left blank intentionally];

2.29.1.3.3 A full-time Medical Director dedicated to the TennCare program who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;

2.29.1.3.4 A full-time senior executive dedicated to the TennCare program who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. This person shall oversee and be responsible for all behavioral health activities;

2.29.1.3.5 A full-time senior executive dedicated to the TennCare CHOICES program who has at least five (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted, subject to the prior approval of TENNCARE This person shall oversee and be responsible for all CHOICES activities;

2.29.1.3.5.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of CHOICES in the Grand Region covered by this Agreement;

2.29.1.3.5.2 If the CONTRACTOR has not filled this position one hundred and eighty (180) days prior to the scheduled implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall designate another senior executive dedicated to the TennCare program to temporarily oversee CHOICES implementation activities, as prior approved by TENNCARE, until this position

is filled (which, as specified in Section 2.29.1.3.5.1 above, shall be at least one hundred and twenty (120) days prior to the scheduled implementation of CHOICES). Should another senior executive be temporarily designated to oversee CHOICES implementation activities, upon filling the full-time position as specified in Section 2.29.1.3.5.1 above, the CONTRACTOR shall ensure the effective transition of all CHOICES implementation activities, including a minimum transition period of ninety (90) days;

2.29.1.3.6 A full-time chief financial officer dedicated to the TennCare program responsible for accounting and finance operations, including all audit activities;

2.29.1.3.7 A full-time staff information systems director/manager dedicated to the TennCare program responsible for all CONTRACTOR information systems supporting this Agreement who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting this Agreement including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;

2.29.1.3.8 A staff person designated as the contact available after hours for the "on-call" TennCare Solutions staff to contact with service issues;

2.29.1.3.9 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

2.29.1.3.10 A full-time staff person dedicated to the TennCare program responsible for member services, who shall communicate with TENNCARE regarding member service activities;

2.29.1.3.11 A full-time staff person dedicated to the TennCare program responsible for provider services and provider relations, including all network development and management issues. This person shall be responsible for appropriate education regarding provider participation in the TennCare (including CHOICES) program; communications between the CONTRACTOR and its contract providers; and ensuring that providers receive prompt resolution of problems or inquiries. This person shall also be responsible for communicating with TENNCARE regarding provider service and provider relations activities. The FEA shall be responsible for education of and communication with consumer-directed workers, resolution of problems or inquiries from workers, and communication with TENNCARE regarding workers;

2.29.1.3.12 A full-time staff person dedicated to the TennCare CHOICES program responsible for educating and assisting long-term care providers and the FEA regarding

appropriate claims submission processes and requirements, coding updates, electronic claims transactions and electronic funds transfer; for the development and maintenance of CONTRACTOR resources such as CHOICES provider manuals, website, fee schedules, etc.; for technical assistance regarding long-term care claims submission and resolution processes; and for prompt resolution of long-term care claims issues or inquiries as specified in Section 2.22.5. This person shall develop strategies to assess the effectiveness of the CONTRACTOR'S claims education and technical assistance activities, gather feedback regarding the extent to which CHOICES providers are informed about appropriate claims submission processes and practices, and identify trends and guide the development of strategies to improve the efficiency of long-term care claims submission and resolution processes, as well as CHOICES provider satisfaction;

2.29.1.3.13 A staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement;

2.29.1.3.14 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;

2.29.1.3.15 A staff person responsible for all quality management activities. This person shall be a physician or registered nurse licensed in the State of Tennessee;

2.29.1.3.16 A staff person responsible for all appeal system resolution issues;

2.29.1.3.17 A staff person responsible for all claims management activities;

2.29.1.3.18 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;

2.29.1.3.19 A staff person responsible for all MCO case management and related issues, including but not limited to, disease management activities and coordination between physical and behavioral health services;

2.29.1.3.20 A full-time staff person dedicated to the TennCare CHOICES program who is a registered nurse and has at least three (3) years experience providing care coordination to persons receiving long-term care services and an additional two (2) years work experience in managed and/or long-term care. This person shall oversee and be responsible for all care coordination activities.

2.29.1.3.21 A sufficient number of CHOICES care coordinators that meet the qualifications in Section 2.9.6.11 to conduct all required activities as specified herein;

2.29.1.3.22 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members' interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;

2.29.1.3.23 A consumer advocate for CHOICES members. This person shall be responsible for internal representation of CHOICES members' interests including but not limited to input into planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family, and provider education. The consumer advocate shall also assist CHOICES members in navigating the CONTRACTOR's system (e.g., how to file a complaint, how to change care coordinators). This shall include, but not be limited to, helping members understand and use the CONTRACTOR's system, e.g., being a resource for members, providing information, making referrals to appropriate CONTRACTOR staff, and facilitating resolution of any issues. The consumer advocate shall also make recommendations to the CONTRACTOR on any changes needed to improve the CONTRACTOR's system for CHOICES members, make recommendations to TENNCARE regarding improvements for the CHOICES program, and participate as an ex officio member of the CHOICES Advisory Group required in Section 2.24.3;

2.29.1.3.24 A staff person responsible for TENNderCare services;

2.29.1.3.25 A staff person responsible for working with the Department of Children's Services;

2.29.1.3.26 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;

2.29.1.3.27 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the DBM Care Coordination Committee and the DBM Claims Coordination Committee as described in Section 2.9.11;

2.29.1.3.28 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination; and

2.29.1.3.29 A staff person designated for interfacing and coordinating with the TDMHDD Planning and Policy Council.

2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, MCO case management, disease management, care coordination, quality management, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.

2.29.1.5 The CONTRACTOR shall have a sufficient number of DBM care coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.

2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section 2.21.10.

2.29.1.7 At least one hundred and twenty (120) days prior to the scheduled implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR

shall establish a team dedicated to the implementation of the CHOICES program. This team shall be responsible for directing and overseeing all aspects of the implementation of CHOICES. The team shall be led by the full-time senior executive referenced in Section 2.29.1.3.5 above and shall include, at a minimum, a staff person with responsibility for developing and implementing the CONTRACTOR's care coordination program, a staff person responsible for long-term care provider network development and provider relations, a staff person responsible for CHOICES provider claims education and assistance, a staff person responsible for long-term care QM/QI, a staff person responsible for IS issues related to CHOICES, and other staff as necessary to ensure the successful implementation of the CHOICES program and the seamless transition of members currently receiving long-term care services. The team shall report directly to the CONTRACTOR's senior management and shall interface with all of the CONTRACTOR's departments/business units as necessary to ensure the CONTRACTOR's readiness to provide services to CHOICES members in compliance with the requirements of this Agreement.

2.29.1.8 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section 2.29.1.3. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.

2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, UM staff, appeals staff, MCO case management staff, care coordination staff, consumer advocate, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.

2.29.1.10 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

2.29.2 **Licensure and Background Checks**

2.29.2.1 Except as specified in this Section 2.29.2.1 regarding the FEA, the CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law. The FEA shall be responsible for ensuring that consumer-directed workers are qualified to provide HCBS in accordance with TENNCARE requirements.

2.29.2.2 Except as specified in this Section 2.29.2.2 regarding the FEA, the CONTRACTOR is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR conducts background checks

in accordance with state law and TennCare policy. The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers.

2.29.3 **Board of Directors**

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

2.29.4 **Employment and Contracting Restrictions**

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:

2.29.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;

2.29.4.2 Have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

2.29.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section 2.29.4.2 of this Agreement; and

2.29.4.4 Have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

26. Section 2.30 shall be deleted in its entirety and replaced with the following:

2.30 REPORTING REQUIREMENTS

2.30.1 **General Requirements**

2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports.

2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.

2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Agreement, according to the schedule below:

DELIVERABLES		DUE DATE
Daily Reports		Within two (2) business days.
Weekly Reports		Wednesday of the following week.
Monthly Reports		20th of the following month.
Quarterly Reports		30th of the following month.
Semi-Annual Reports		January 31 and July 31.
Annual Reports		Ninety (90) calendar days after the end of the calendar year
On Request Reports		Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.
Ad Hoc Reports		Within ten (10) business days from the date of the request unless otherwise specified by TENNCARE.

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE. Except as otherwise specified by TENNCARE, all reports shall be specific to the Grand Region covered by this Agreement.

2.30.1.5 Except as otherwise provided in this Agreement, the CONTRACTOR shall submit all reports to the Bureau of TennCare.

2.30.1.6 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.1.7 As part of its QM/QI program, the CONTRACTOR shall review all reports submitted to TENNCARE to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward.

2.30.2 **Eligibility, Enrollment and Disenrollment Reports**

2.30.2.1 The CONTRACTOR shall comply with the requirements in Section 2.23.5 regarding eligibility and enrollment data exchange.

2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Capitation Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with capitation payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received a capitation payment, and that all members for whom the CONTRACTOR received a CHOICES capitation payment are identified as CHOICES members in the appropriate CHOICES Group on the enrollment record.

2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Capitation Payment Report* in the event it has members for whom a capitation payment has not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise.

2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.

2.30.3 **LEFT BLANK INTENTIONALLY**

2.30.4 **Specialized Service Reports**

2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18).

2.30.4.2 The CONTRACTOR shall submit a quarterly *Mental Health Case Management Report* that provides information on mental health case management appointments and refusals (see Section 2.7.2.6). The minimum data elements required are identified in Attachment IX, Exhibit B.

2.30.4.3 The CONTRACTOR shall submit an annual *Supported Employment Report* that reports on the percent of SPMI adults receiving supported employment services that

are gainfully employed in either part-time or full-time capacity for a continuous ninety (90) day period (defined as the number of adults receiving supported employment for a continuous ninety (90) day period divided by the number of SPMI adults receiving supported employment services during the year) and an analysis of the findings with any action or follow-up planned as a result of the findings.

2.30.4.4 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements listed in Attachment IX, Exhibit C. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all data elements shall be reported for each individual crisis service provider.

2.30.4.5 The CONTRACTOR shall submit a weekly *Member CRG/TPG Assessment Report* that contains information regarding the CRG assessments and TPG assessments (see Section 2.7.2.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. For purposes of this weekly *Member CRG/TPG Assessment Report*, the weekly report shall be due no later than 12:00 Noon, each Tuesday. The minimum data elements required are identified in Attachment IX, Exhibit D of this Agreement.

2.30.4.6 On a quarterly basis the CONTRACTOR shall submit a *Rejected CRG/TPG Assessments Report* that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments.

2.30.4.7 The CONTRACTOR shall submit an annual *CRG/TPG Assessments Audit Report*. The report shall contain the results of the CONTRACTOR's audits for the prior year of CRG/TPG assessments for accuracy and conformity to state policies and procedures.

2.30.4.8 The CONTRACTOR shall annually submit to TENNCARE its methodology for conducting the CRG/TPG assessment audits on March 1.

2.30.4.9 The CONTRACTOR shall submit a quarterly *Adverse Occurrences Report* that summarizes all adverse occurrences and their resolutions as reported to the CONTRACTOR by its providers.

2.30.4.10 The CONTRACTOR shall submit a quarterly *TENNderCare Report*.

2.30.4.11 The CONTRACTOR shall submit a quarterly *Self-Directed Health Care Tasks Report*. The report shall include current and cumulative information, by month, on various measures. Initially the performance measure will be the following:

(1) Number and percent of CHOICES members self-directing health care tasks

Upon expansion of self-directed health care tasks to include additional tasks, the performances measures shall also include but not be limited to the following:

(1) Of CHOICES members self-directing health care tasks, the number and percent by type of health care task that is self-directed

(2) Of CHOICES members self-directing health care tasks, the number and percent who, overall and by task, use:
   (a) A community-based residential alternative provider, other than a companion care model
   (b) A companion care model
   (c) A non-residential provider
   (d) A consumer-directed worker
   (e) Both a non-residential provider and a consumer-directed worker

The cumulative information shall include information on each of the measures by and across previous months on a rolling twelve (12) month basis, and the CONTRACTOR shall provide a graphical (as well as numeric) representation of current and cumulative information.

The CONTRACTOR shall submit its first report following the first calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the first calendar quarter.

2.30.5 **Disease Management Reports**

2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter.

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

2.30.5.3 The CONTRACTOR shall submit a quarterly *Disease Management for CHOICES Update Report.*

2.30.5.3.1 The first report shall be submitted after the first calendar quarter after CHOICES implementation in the Grand Region covered by this Agreement and shall provide a narrative description of the CONTRACTOR's proposed approach to disease

management for CHOICES members for four of the six disease management (DM) conditions listed in Sections 2.8.1.1.2, 2.8.1.1.3, 2.8.1.1.5, 2.8.1.1.6, 2.8.1.1.8, and 2.8.8). This shall include but not be limited to identifying the four DM conditions that will be targeted for the next six months, the proposed stratification levels including member criteria and the proposed associated member/caregiver and provider interventions for each DM condition, which shall include targeted interventions based on the setting in which the member resides.

2.30.5.3.2 The report for the second calendar quarter after CHOICES implementation shall provide an update regarding the CONTRACTOR's progress in implementing the four disease management programs identified by the CONTRACTOR in the first report, including the stratification levels including member criteria and proposed associated member/caregiver and provider interventions for each DM condition; number of members who have been identified, by stratification level and associated proposed member/caregiver and provider interventions; and any other disease management activities that have been conducted for the population.

2.30.5.3.3 The report for the third calendar quarter after CHOICES implementation shall include, for each of the four disease management programs identified by the CONTRACTOR in the first report, a brief narrative description of any changes, opportunities or barriers regarding these DM programs; the total number of CHOICES members receiving DM interventions for the four selected conditions, by DM condition; the total number of CHOICES members starting and terminating DM interventions during the quarter, a description of the specific provider and member interventions that were new during the quarter, the number of member and provider activities/interventions conducted, by activity/intervention, and a written analysis of data provided.

2.30.5.3.4 The report for the fourth calendar quarter after CHOICES implementation shall include the same type of information as in the report for the third quarter (see Section 2.30.5.3.3) as well as the CONTRACTOR's proposed approach to disease management for CHOICES members for the two DM conditions listed in Sections 2.8.1.1.2, 2.8.1.1.3, 2.8.1.1.5, 2.8.1.1.6, 2.8.1.1.8, 2.8.8) for which the CONTRACTOR has not developed a DM program for CHOICES members. This shall include but not be limited to the elements listed in Section 2.30.5.3.2 for each of the two DM programs.

2.30.5.3.5 The report for the fifth calendar quarter after CHOICES implementation shall include the same type of information as in the report for the third quarter (see Section 2.30.5.3.3) for each of the six DM programs implemented by the CONTRACTOR for CHOICES members.

2.30.5.3.6 The report for the sixth calendar quarter after CHOICES implementation shall include the same type of information as in the fifth calendar quarter report (see Section 2.30.5.3.5) as well as the CONTRACTOR's proposed approach to disease management for CHOICES members for the three DM conditions listed in Sections 2.8.1.1.4, 2.8.1.1.7, and 2.8.1.1.9.

2.30.5.3.7 The report for the seventh calendar quarter after CHOICES implementation shall include the same type of information as in the report for the third quarter (see Section

2.30.5.3.3) for each of the nine DM programs implemented by the CONTRACTOR for CHOICES members.

2.30.5.4 The CONTRACTOR shall submit on July 1 an annual *Disease Management for CHOICES Report* that includes, for each disease management program implemented by the CONTRACTOR (see Section 2.8.1.7), a narrative description of the eligibility criteria and the method used to identify and enroll eligible CHOICES members; a description of stratification levels including member criteria and associated member and provider interventions, which shall include targeted interventions 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 passive participation rate of CHOICES members; number of CHOICES members by level of stratification and intervention; outcome measures; a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation; evaluation of member satisfaction with activities/interventions; and a description of proposed changes.

2.30.5.5 The CONTRACTOR shall submit annually an updated *Disease Management Program Description* to include at a minimum the disease management components listed in Sections 2.8.1.4 through 2.8.1.5 of this Agreement and an updated *Disease Management Program Description for CHOICES* to include at a minimum the disease management components listed in Section 2.8.1.6 of this Agreement.

2.30.6 **Service Coordination Reports**

2.30.6.1 <u>MCO Case Management Reports</u>

2.30.6.1.1 The CONTRACTOR shall submit annually an updated *MCO Case Management Program Description* to TENNCARE describing the CONTRACTOR's MCO case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for MCO case management, the process the CONTRACTOR uses to inform members and providers of the availability of MCO case management, a description of the MCO case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its MCO case management program.

2.30.6.1.2 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.5 of this Agreement by July 1 of each year.

2.30.6.1.3 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report*. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management.

2.30.6.2 For the first six (6) months after implementation of CHOICES in the Grand Region covered by this Agreement, or as long as determined necessary by TENNCARE, the CONTRACTOR shall submit a monthly *Status of Transitioning CHOICES Members Report* that provides information regarding transitioning CHOICES members (see Section 2.9.3). The report shall include information on the CONTRACTOR's current and cumulative performance on various measures.

The performance measures shall include but not be limited to the following:

(1) Of CHOICES Group 1 members who were enrolled in CHOICES as of the CHOICES implementation date, the number and percent for whom the CONTRACTOR has/has not conducted a face-to-face visit (see Section 2.9.3.7)

(2) Of CHOICES Group 2 members who were enrolled in CHOICES as of the CHOICES implementation date, the number and percent for whom the CONTRACTOR has/has not conducted face-to-face visit and a comprehensive needs assessment and developed and authorized a new plan of care

If, at the expiration of any one of the timeframes specified in Section 2.9.3, the CONTRACTOR's performance for the measure is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the date that the applicable activity will/did occur, and why the CONTRACTOR exceeded the timeframe. The CONTRACTOR shall submit a follow-up exceptions report until the CONTRACTOR has conducted the required activities for each member.

2.30.6.3 The CONTRACTOR shall submit a quarterly *New Member Assessment and Care Planning and Initiation of Services Report* that provides information regarding assessment, care planning, and initiation of services for CHOICES members who are enrolled through the SPOE. The report shall include information on the CONTRACTOR's performance, by month, on various measures; an exceptions report (as applicable); a cumulative report; and a performance improvement plan (as applicable).

The performance measures shall include but not be limited to the following:

(1) Of CHOICES Group 1 members enrolled through the SPOE who, at the time of CHOICES enrollment, had been residing in a nursing facility for ninety (90) days or more and are due for a face-to-face visit in the month, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for a face-to-face visit (see Section 2.9.6.2.4.2)

(2) Of CHOICES Group 1 members enrolled through the SPOE who, at the time of CHOICES enrollment, were recently admitted to a nursing facility and are due for a face-to-face visit in the month, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for a face-to-face visit (see Section 2.9.6.2.4.3)

(3) Of CHOICES Group 1 members enrolled through the SPOE who will be admitted to a nursing facility and are due for a face-to-face visit in the month, the number and percent for whom the CONTRACTOR met /did not meet the

specified timeframe for a face-to-face visit and initiation of nursing facility services (see Section 2.9.6.2.4.4)

(4) Of CHOICES Group 2 and Group 3 members enrolled through the SPOE who are due for a face-to-face visit in the month, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for conducting a face-to-face visit and initiating ongoing HCBS (as defined in Section 1) identified in the member's plan of care (see Section 2.9.6.2.5)

If the CONTRACTOR's performance for the reporting period for any one of the timeframe measures is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the actual date that the applicable activity occurred (if it occurred within the reporting period), the date that the applicable activity will occur (if it did not occur within the reporting period), and why the CONTRACTOR exceeded the timeframe.

Each quarterly report shall also include a cumulative report that includes: (1) a follow-up exceptions report that provides updated information on the exceptions reported in the previous report that identifies any members for whom the CONTRACTOR did not remediate on the date specified in the previous exceptions report; (2) for each month in the previous twelve (12) months, for each timeframe measure, the CONTRACTOR's performance; and (3) over the previous months on a rolling twelve (12) month basis, for each timeframe measure, the minimum, maximum, median, and average amount of time that it took the CONTRACTOR to complete the applicable activity, which shall include instances where the activity was completed after the specified timeframe, as compared to the timeframe specified in this Agreement for that measure. The report shall include a graphical representation of current and cumulative information.

If the CONTRACTOR's failure to meet the timeframes is systemic, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for non-compliance, actions taken/to be taken by the CONTRACTOR to ensure compliance, the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

2.30.6.4 The CONTRACTOR shall submit a quarterly *CHOICES Intake, Enrollment, and Service Initiation Report* regarding the CONTRACTOR's CHOICES intake process for current members who may be eligible for CHOICES. The report shall include information on the CONTRACTOR's performance, by month, on various measures; an exceptions report (as applicable); a cumulative report; and a performance improvement plan (as applicable).

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following:

(1) Number of members identified as potentially eligible for CHOICES

(2) Of members due for a CHOICES intake visit, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for conducting a CHOICES intake visit (see Section 2.9.6.3)

(3) Of the members identified for whom the CONTRACTOR conducted a telephone screening process, the number and percent who:
   (a) Met the screening criteria
   (b) Did not meet the screening criteria, by reason
   (c) Did not meet the screening criteria and submitted a written request to proceed with CHOICES intake
   (d) Did not meet the screening criteria, submitted a written request to proceed with CHOICES intake, and were enrolled in CHOICES (or put on the waiting list if not enrolled in Group 2 as a CEA)

(4) Of the members identified, the number and percent who were enrolled in CHOICES or put on the waiting list, overall and by CHOICES Group

(5) Of members for whom the CONTRACTOR conducted CHOICES intake and due for initiation of services, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for initiating nursing facility or ongoing HCBS, as applicable (see Section 2.9.6.3.17)

Starting the thirteenth month after CHOICES implementation, the performance shall include but not be limited to the following:

(1) Number of members identified as potentially eligible for CHOICES in each month, the number and percent identified through:
   (a) Referrals by referral source, including each designee agency
   (b) Notice of hospital admission
   (c) Data review (not referral or hospital admission)

(2) Of members identified as potentially eligible for CHOICES in each month, the number and percent for whom the CONTRACTOR conducted a telephone screening in the reporting quarter, overall and by:
   (a) Members referred
   (b) Members identified by data review (not referral or hospital admission)

(3) Of members identified through referral due for a CHOICES intake visit, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for conducting a CHOICES intake visit (see Section 2.9.6.3.10)

(4) Of members identified by data review (not referral or hospital admission) due for a CHOICES intake visit, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for conducting a CHOICES intake visit (see Section 2.9.6.3.11)

(5) Of members for whom the CONTRACTOR conducted a telephone screening process, the number and percent, overall and by type of identification (referral, hospital admission, or data analysis), who:
   (a) Met the screening criteria
   (b) Did not meet the screening criteria, by reason
   (c) Did not meet the screening criteria and submitted a written request to proceed with CHOICES intake
   (d) Did not meet the screening criteria, submitted a written request to proceed with CHOICES intake, and were enrolled in CHOICES (or put on a waiting list)

(6) Of the members who submitted a written request to proceed with CHOICES intake and due for a CHOICES intake visit, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for conducting a CHOICES intake visit (see Section 2.9.6.3.7)

(7) Of members identified by referral, the number and percent who were enrolled in CHOICES or put on a waiting list, overall and by CHOICES Group and by referral source

(8) Of members identified through notice of hospital admission, the number and percent who were enrolled in CHOICES or put on a waiting list, overall and by CHOICES Group

(9) Of members identified by data review (not referral or hospital admission), the number and percent who were enrolled in CHOICES or put on a waiting list, overall and by CHOICES Group

(10) Of members in Group 1 for whom the CONTRACTOR conducted CHOICES intake and were due for initiation of services, the number and percent for whom, the CONTRACTOR met/did not meet the specified timeframe for initiating nursing facility services (see Section 2.9.6.3.17)

(11) Of CHOICES members in Group 2 or 3 for whom the CONTRACTOR conducted CHOICES intake and were due for initiation of services, the number and percent for whom, overall and by service, the CONTRACTOR met/did not meet the specified timeframe for initiating ongoing HCBS identified in the member's plan of care (see Section 2.9.6.3.17)

(12) Of CHOICES members in Group 2 or 3 for whom the CONTRACTOR conducted CHOICES intake and were due for initiation of services, the number and percent for whom, overall and by service, the CONTRACTOR met/did not meet the specified timeframe for initiating one-time HCBS (as defined in Section 1) identified in the member's plan of care (see Section 2.9.6.3.17)

If the CONTRACTOR's performance for any one of the timeframe measures is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet

the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the actual date that the applicable activity occurred (if it occurred within the reporting period), the date that the applicable activity will occur (if it did not occur within the reporting period), and why the CONTRACTOR exceeded the timeframe.

Each quarterly report shall also include a cumulative report that includes: (1) a follow-up exceptions report that provides updated information on the exceptions reported in the previous report that identifies any members for whom the CONTRACTOR did not remediate on the date specified in the previous exceptions report; (2) for each month in the previous twelve (12) months, for each timeframe measure, the CONTRACTOR's performance; (3) over the previous months on a rolling twelve (12) month basis, for each timeframe measure, the minimum, maximum, median, and average amount of time that it took the CONTRACTOR to complete the applicable activity, which shall include instances where the activity was completed after the specified timeframe, as compared to the timeframe specified in this Agreement for that measure; and (4) for any non-timeframe measures, the information by and across previous months on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

If the CONTRACTOR's failure to meet the timeframes is systemic, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for non-compliance, actions taken/to be taken by the CONTRACTOR to ensure compliance, the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

2.30.6.5 The CONTRACTOR shall submit a quarterly *Ongoing Assessment and Care Planning and Service Initiation Report* that provides information regarding ongoing assessment and care planning and service initiation timeframes. The report shall include information on the CONTRACTOR's performance, by month, on various measures; an exceptions report (as applicable); a cumulative report; and a performance improvement plan (as applicable).

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following:

(1) Of CHOICES members due for an annual level of care assessment, the number and percent for whom the CONTRACTOR conducted/did not conduct an annual level of care assessment, overall and by CHOICES Group

(2) Of CHOICES members in Group 2 due for an annual needs assessment, the number and percent for whom the CONTRACTOR conducted/did not conduct an annual needs reassessment and an annual plan of care update

Starting the thirteenth month following CHOICES implementation, the performance shall include but not be limited to the following:

(1) Of CHOICES Group 2 and 3 members due for inclusion of the additional elements in their plan of care, the number and percent for whom the

CONTRACTOR met/did not meet the specified timeframe for including additional elements in the member's plan of care (see Section 2.9.6.6.2.5)

(2) Of CHOICES members due for an annual level of care assessment, the number and percent for whom the CONTRACTOR conducted/did not conduct an annual level of care assessment, overall and by CHOICES Group

(3) Of CHOICES Group 1 members, the number and percent with a supplemental plan of care

(4) Of CHOICES members in Group 2 and 3 due for an annual needs assessment, the number and percent for whom the CONTRACTOR conducted/did not conduct an annual needs reassessment and an annual plan of care update, overall and by CHOICES Group

(5) Of CHOICES members in Groups 2 and 3 whose plan of care was updated and due and were due for initiation of services, the number and percent for whom, overall and by service, the CONTRACTOR met the specified timeframe for initiating ongoing HCBS in the updated of plan of care (see Section 2.9.6.6.2.8)

(6) Of CHOICES members in Groups 2 and 3 whose plan of care was updated and due and were due for initiation of services, the number and percent for whom, overall and by service, the CONTRACTOR met the specified timeframe for initiating one-time HCBS (as defined in Section 1) in the updated of plan of care (see Section 2.9.6.6.2.8)

If the CONTRACTOR's performance for the reporting period for any one of the timeframe measures is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the actual date that the applicable activity occurred (if it occurred within the reporting period), the date that the applicable activity will occur (if it did not occur within the reporting period), and why the CONTRACTOR exceeded the timeframe.

Each quarterly report shall also include a cumulative report that includes: (1) a follow-up exceptions report that provides updated information on the exceptions reported in the previous report that identifies any members for whom the CONTRACTOR did not remediate on the date specified in the previous exceptions report; (2) for each month in the previous twelve (12) months, for each timeframe measure, the CONTRACTOR's performance; (3) over the previous months on a rolling twelve (12) month basis, for each timeframe measure, the minimum, maximum, median, and average amount of time that it took the CONTRACTOR to complete the applicable activity, which shall include instances where the activity was completed after the specified timeframe, as compared to the timeframe specified in this Agreement for that measure; and (4) for any non-timeframe measures, the

information by and across previous months on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter after CHOICES implementation.

If the CONTRACTOR's failure to meet the timeframes is systemic, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for non-compliance, actions taken/to be taken by the CONTRACTOR to ensure compliance, the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

2.30.6.6 The CONTRACTOR shall submit a quarterly *Post-Enrollment Care Coordinator Contact Report* that provides information on care coordinator contacts with CHOICES members occurring after the member's enrollment in CHOICES. The report shall include information on the CONTRACTOR's performance, by month, on various measures; an exceptions report (as applicable); a cumulative report; and a performance improvement plan (as applicable).

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following:

(1) Of members in Group 1 due for a face-to-face visit in the month, the number and percent for whom the care coordinator did/did not conduct a face-to-face visit

(2) Of members in Group 2 due for a face-to-face contact in the month, the number and percent for whom the care coordinator did/did not conduct a face-to-face visit

Starting the thirteenth month following CHOICES implementation, in addition to the performance measures for the first twelve (12) months, the performance measures shall include but not be limited to the following:

(1) Of new members in Group 2 and 3 due for contact after initiation of HCBS, the number and percent for whom, the CONTRACTOR met/did not meet the specified timeframe for contacting the member after initiation of HCBS (see Section 2.9.6.9.4.3.4)

(2) Of members in Group 2 and 3 admitted to a nursing facility where the admission was not authorized by the CONTRACTOR and due for a face-to-face visit, the number and percent for whom the CONTRACTOR met/did not meet the specified timeframe for contacting the member after notice of admission (see Section 2.9.6.9.4.3.2)

(3) Of members in Group 2, the number and percent the care coordinator did/did not contact, overall and by type of contact (phone or face-to-face)

(4) Of members in Group 3 due for a contact in the month, the number and percent the care coordinator did/did not contact, overall and by type of contact

(5) Of members in Group 3 due for a face-to-face contact in the month, the number and percent the care coordinator did/did not conduct a face-to-face visit

(6) For members in Groups 2 and 3 due for a contact after initiation of HCBS in an updated plan of care, the number and percent for whom, the CONTRACTOR met/did not meet the specified timeframe for contacting the member after initiating HCBS in the updated plan of care (see Section 2.9.6.4.3.5)

If the CONTRACTOR's performance for any one of these measures is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the actual date that the applicable activity occurred (if it occurred within the reporting period), the date that the applicable activity will occur (if it did not occur within the reporting period), and why the CONTRACTOR exceeded the timeframe.

Each quarterly report shall also include a cumulative report that includes: (1) a follow-up exceptions report that provides updated information on the exceptions reported in the previous report that identifies any members for whom the CONTRACTOR did not remediate on the date specified in the previous exceptions report; (2) for each month in the previous twelve (12) months, for each timeframe measure, the CONTRACTOR's performance; (3) over the previous months on a rolling twelve (12) month basis, for each timeframe measure, the minimum, maximum, median, and average amount of time that it took the CONTRACTOR to complete the applicable activity, which shall include instances where the activity was completed after the specified timeframe, as compared to the timeframe specified in this Agreement for that measure; and (4) for any non-timeframe measures, the information by and across previous months on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

If the CONTRACTOR's failure to meet the timeframes is systemic, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for non-compliance, actions taken/to be taken by the CONTRACTOR to ensure compliance, the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

2.30.6.7 The CONTRACTOR shall submit a semi-annual *Nursing Facility Diversion Report* regarding CHOICES members who have been diverted from a nursing facility to the community. The report shall describe the CONTRACTOR's nursing facility diversion activities by each of the groups identified in Section 2.9.6.7, the CONTRACTOR's success in identifying and diverting members and maintaining

members in the community and lessons learned, including factors affecting the CONTRACTOR's ability to divert members, identified issues, strategies to address identified issues, and opportunities for systemic improvements in the CONTRACTOR's nursing facility diversion process.

2.30.6.8 The CONTRACTOR shall submit a quarterly *Nursing Facility to Community Transition Report* regarding CHOICES members who have been identified as potentially eligible for transition from a nursing facility setting to the community. The report shall include information, by month, on various performance measures; as applicable, an exceptions report, a follow-up exceptions report, and a performance improvement plan; and a cumulative report.

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following:

(1) Number of CHOICES members in Group 1 identified as potential candidates for transition

(2) Number of Group 1 members identified as candidates for transition

(3) Number of transition assessments conducted

(4) Number of members identified as candidates for transition who were transitioned/not transitioned to the community within ninety (90) days

(5) Of members who transitioned to the community, the number and percent of members who transitioned to:
   (a) A community-based residential alternative facility (by type)
   (b) A residential setting where the member will be living independently
   (c) A residential setting other than (a) or (b) (i.e., where the member will be living with a relative or other caregiver)

(6) Of CHOICES members who transitioned to live independently in the community or whose on-site visit during transition planning indicated an elevated risk and were due for the applicable contact, the number and percent for whom:
   (a) The CONTRACTOR met/did not meet the timeframe for contact within twenty-four (24) hours after transition
   (b) The CONTRACTOR met/did not meet the timeframe for contact within the first month of transition
   (c) The CONTRACTOR met/did not meet the timeframe for contact in the second month of transition
   (d) The CONTRACTOR met/did not meet the timeframe for contact in the third month of transition

(7) Of CHOICES members who transitioned to a community-based residential alternative setting or to live with a relative or other caregiver and were due for the applicable contact, the number and percent for whom:
   (a) The CONTRACTOR met/did not meet the timeframe for contact within twenty-four (24) hours after transition

(b) The CONTRACTOR met/did not meet the timeframe for contact within the first seven days of transition
(c) The CONTRACTOR met/did not meet the timeframe for contact within the first month of transition
(d) The CONTRACTOR met/did not meet the timeframe for contact in the second month of transition
(e) The CONTRACTOR met/did not meet the timeframe for contact in the third month of transition

(8) Number of members transitioned to the community who were re-admitted to a nursing facility in ninety (90) days or less

(9) Number of members transitioned to the community who were re-admitted to a nursing facility in greater than ninety (90) days

Starting the thirteenth month following CHOICES implementation, in addition to performance measures (5) through (7) identified above for the first twelve months, the performance measures shall include but not be limited to the following:

(1) Number of CHOICES members in Group 1 identified as potential candidates for transition in the month, overall and the:
(a) Number and percent of potential candidates who were referred to the CONTRACTOR
(b) Number and percent of potential candidates who were identified from the MDS
(c) Number and percent of potential candidates whom the CONTRACTOR identified through the care coordination process
(d) Number and percent of potential candidates whom the CONTRACTOR identified other than through referral, MDS, or the care coordination process (and an explanation of how these members were identified)

(2) Of members identified by the CONTRACTOR as potential candidates for transition, overall and by source of identification:
(a) Of those who had an initial visit, the number and percent who indicated that they wanted/did not want to pursue transition
(b) Of those for whom the CONTRACTOR conducted a transition assessment, the number and percent whom the CONTRACTOR determined were/were not candidates for transition, overall and by reason
(c) Number and percent who (i) were transitioned to the community or (ii) are still in the transitioning process

(3) Of CHOICES members transitioned from a nursing facility who were subsequently re-admitted to a nursing facility, the number and percent, overall and by Group, who remained in the community before nursing facility admission for:
(a) <30 days
(b) 30-89 days
(c) 90-179 days
(d) 180 or more days

(4) The fourth quarter report shall include:

(a) Of members transitioned from a nursing facility, the number and percent who received a transition allowance
(b) The minimum, maximum, median, and average transition allowance amount per member
(c) The minimum, maximum, median, and average transition allowance amount per transition item
(d) The frequency with which a transition allowance is authorized per item

If the CONTRACTOR's performance for any one of the timeframe measures is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the actual date that the applicable activity occurred (if it occurred within the reporting period), the date that the applicable activity will occur (if it did not occur within the reporting period), and why the CONTRACTOR exceeded the timeframe.

Each quarterly report shall also include a cumulative report that includes: (1) a follow-up exceptions report that provides updated information on the exceptions reported in the previous report that identifies any members for whom the CONTRACTOR did not remediate on the date specified in the previous exceptions report; (2) for each month in the previous twelve (12) months, for each timeframe measure, the CONTRACTOR's performance; (3) over the previous months on a rolling twelve (12) month basis, for each timeframe measure, the minimum, maximum, median, and average amount of time that it took the CONTRACTOR to complete the applicable activity, which shall include instances where the activity was completed after the specified timeframe, as compared to the timeframe specified in this Agreement for that measure; and (4) for any non-timeframe measures, the information by and across previous months on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter after CHOICES implementation.

Each year, with the fourth quarter report, the CONTRACTOR shall submit a narrative that describes the CONTRACTOR's nursing facility transition activities and the CONTRACTOR's success in identifying and transitioning members and maintaining members in the community and lessons learned, including factors affecting the CONTRACTOR's ability to transition members, identified issues, strategies to address identified issues, and opportunities for systemic improvements in the CONTRACTOR's nursing facility transition process.

If the CONTRACTOR's failure to meet the timeframes is systemic, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for non-compliance, actions taken/to be taken by the CONTRACTOR to ensure compliance,

the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

2.30.6.9 The CONTRACTOR shall submit a monthly *HCBS Missed Visits Report* for CHOICES members regarding the following HCBS services: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include current and cumulative information on various performance measures, a summary report, and, as applicable, a performance improvement plan.

The performance measures shall include but not be limited to the following:

(1) The number and percent of members in Groups 2 and 3, by Group, who had:
- (a) A late visit (for any reason)
- (b) A missed visit by type of reason (member initiated, provider initiated, or severe inclement weather)

(2) The number and percent of visits, overall, by service, and by type of provider (agency or worker), that were:
- (a) Late, by type of reason
- (b) Missed, by type of reason

(3) The minimum, maximum, median, and average number and percent of visits by member that were late for a provider initiated reason, overall and by:
- (a) Service type
- (b) Type of provider (agency or worker)

(4) The minimum, maximum, median, and average number and percent of visits by member that were missed for a provider initiated reason, overall and by:
- (a) Service type
- (b) Type of provider (agency or worker)

(5) Of members in Groups 2 and 3 (by Group), the number and percent who had:
- (a) One missed visit that was provider initiated
- (b) Two missed visits that were provider initiated
- (c) Etc.

(6) Of all agency HCBS providers, the number and percent with:
- (a) 5% of visits missed (provider initiated)
- (b) 10% of visits missed (provider initiated)
- (c) Etc.

(7) Of consumer-directed workers, the number and percent with:
- (a) 5% of visits missed (provider initiated)
- (b) 10% of visits missed (provider initiated)
- (c) Etc.

(8) Number and percent of missed visits that were remediated before the next scheduled visit, overall and by service

The CONTRACTOR shall provide information on each of these measures by and across previous months on a twelve (12) month rolling basis and shall include a graphical representation of current and cumulative information.

The summary report shall analyze the reasons for late and missed visits and identify strategies to reduce late and minimize missed visits that are not member initiated going forward, including provider interventions.

If the CONTRACTOR's number of late and/or missed visits indicates a systemic failure, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for missed visits, actions taken/to be taken by the CONTRACTOR to ensure compliance, the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

2.30.6.10 The CONTRACTOR shall submit a semi-annual *Care Coordinator Staffing Report*. The report shall include current information, by month, as well as cumulative information on key performance measures and, as applicable, a performance improvement plan.

The performance measures shall include but not be limited to the following:

(1) Care coordinator turnover rate (number of care coordinators separating during the time period divided by the number of care coordinators)

(2) Minimum, maximum, median, and average months of employment (or contract service) for care coordinators

(3) The care coordinator to CHOICES member ratio overall, for Group 1, and for members receiving HCBS (Groups 2 and 3)

2.30.6.11 The CONTRACTOR shall submit an annual *Care Coordination Quality Assurance Plan* that describes the monitoring activities that will be conducted by the CONTRACTOR specific to care coordination (including those specified in Section 2.9.6.12) and shall submit a quarterly *Care Coordination Quality Assurance Plan Report* that summarizes the CONTRACTOR's monitoring activities and identifies findings, remediation activities, opportunities for systemic improvement, proposed QI activities, and the timeframe for remediation and QI activities. The CONTRACTOR shall submit its first quarterly report at the end of the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter.

2.30.6.12 The CONTRACTOR shall submit a quarterly *Consumer Direction of HCBS Report*. The report shall include current information, by month, as well as cumulative information on various measures.

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following:

(1) Number and percent of CHOICES members using consumer direction of HCBS overall and by eligible service

(2) Number and percent of CHOICES members using consumer direction who have a representative to direct services on their behalf

(3) Number and percent of CHOICES members who withdrew from consumer direction for all HCBS, overall and by reason

(4) Minimum, maximum, median, and average timeframe from the date of member's written confirmation of his/her decision to participate in consumer direction of HCBS and the date consumer-directed HCBS were initiated

Starting the thirteenth month after CHOICES implementation, the performance measures shall include but not be limited to the performance measures from the first twelve (12) month as well as the following performance measure:

(1) Minimum, maximum, median, and average timeframe from the date of member's written confirmation of his/her decision to participate in consumer direction of HCBS and the date of the CONTRACTOR's referral to the FEA

The CONTRACTOR shall provide information on each of these measures by and across previous months on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter.

2.30.6.13 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.10.3.2).

2.30.6.14 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.

2.30.6.15 The CONTRACTOR shall submit a *Pharmacy Services Report, On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.7 **Provider Network Reports**

2.30.7.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical, behavioral health, and long-term care providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, HCBS providers, and emergency and non-emergency transportation providers. For HCBS providers, the *Provider Enrollment File* shall identify the type(s) of HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver HCBS, by service type. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. The report shall be sorted by provider type. The CONTRACTOR shall submit this report during readiness review, by the 5th of each month, and upon TENNCARE request. Each monthly *Provider Enrollment File* shall include information on all providers of covered services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

2.30.7.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards. (See Section 2.11.1.10.)

2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. This report shall be submitted using the format provided in Attachment IX, Exhibit F. (See Section 2.11.2.)

2.30.7.4 The CONTRACTOR shall submit an annual *Report of Essential Hospital Services* by September 1 of each year. The CONTRACTOR shall use the format in Attachment IX, Exhibit G.

2.30.7.5 The CONTRACTOR shall submit a quarterly *Behavioral Health Initial Appointment Timeliness Report* that shall include the average time between the intake assessment appointment and the member's next scheduled appointment or admission. The report shall provide this information by type of service and shall include an analysis of the findings and any actions or follow-up planned as a result of the findings.

2.30.7.6 The CONTRACTOR shall submit an annual *Long-Term Care Provider Network Development Plan* that includes all of the elements specified in Section 2.11.6.6 of this Agreement.

2.30.7.7 The CONTRACTOR shall submit a quarterly *Long-Term Care Provider Capacity Performance Report* that provides information on the CONTRACTOR's performance with respect to the performance standards and benchmarks established by TENNCARE pursuant to Section 2.11.6.5.

2.30.7.8 The CONTRACTOR shall submit an annual *Qualified Workforce Strategies Report* that includes, at a minimum, a brief description of each of the CONTRACTOR's strategies and associated activities, including partnerships in implementing each strategy/activity; timeframes for implementing each strategy/activity; and the status of each strategy/activity (see Section 2.11.6.7).

2.30.7.9 The CONTRACTOR shall submit an annual *FQHC Report* by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment IX, Exhibit H.

2.30.7.10 The CONTRACTOR shall submit a monthly *Institutions for Mental Diseases (IMD) Out-of-State Report* on the use of IMDs utilized outside of the State of Tennessee. The report shall be submitted by the 5th of each month for the previous month.

2.30.8 **Provider Agreement Report**

The CONTRACTOR shall submit a monthly *Single Case Agreements Report* using the format provided in Attachment IX, Exhibit I. (See Section 2.12.4.)

2.30.9 **Provider Payment Reports**

2.30.9.1 The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.18.)

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

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

2.30.9.4 The CONTRACTOR shall provide a *Reconciliation Report* for the total paid amounts between the funds released for payment to providers and the FEA (for consumer-directed workers), the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within fourteen (14) days of the claims data extract

2.30.10 **Utilization Management Reports**

2.30.10.1 The CONTRACTOR shall annually submit, by July 30th of each year, a UM program description and an associated work plan and evaluation. These documents must be prior approved by the CONTRACTOR's oversight committee prior to submission to TENNCARE. The annual evaluation shall include an analysis of findings and actions taken.

2.30.10.2 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following

the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

2.30.10.3 The CONTRACTOR shall provide quarterly *Cost and Utilization Summaries*. These summaries shall report on services paid during the previous quarter. The summaries shall include all data elements listed in Attachment IX, Exhibit K.

2.30.10.4 The CONTRACTOR shall identify and report the number of members who incurred non-nursing facility claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.

2.30.10.5 The CONTRACTOR shall submit a monthly *CHOICES Utilization Report* that identifies each CHOICES member who has not received any long-term care services within thirty (30), sixty (60), or ninety (90) days; identifies the reason why the member has not received long-term care services; and states whether/when long-term care services will resume.

2.30.10.6 The CONTRACTOR shall submit quarterly *Prior Authorization Reports* that include information, by service and separately for adults and children, on the number of requests received, number processed, number approved, number denied, and denial reason.

2.30.10.7 The CONTRACTOR shall submit a copy of the *Referral Provider Listing* (see Section 2.14.3.5), a data file of the provider information used to create the listing, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the referral provider listings mailed to providers, the date mailed, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section 2.14.3.5.

2.30.10.8 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* to TENNCARE no later than February 28th and August 31st each year identifying interventions initiated for members who exceeded the defined threshold for ED usage.

2.30.11 **Quality Management/Quality Improvement Reports**

.

2.30.11.1 The CONTRACTOR shall annually submit, by July 30, an approved (by the CONTRACTOR's QM/QI Committee) QM/QI Program Description, Associated Work Plan, and Annual Evaluation.

2.30.11.2 The CONTRACTOR shall submit an annual *Report on Performance Improvement Projects* that includes the information specified in Section 2.15.3. The report shall be submitted annually on July 30.

2.30.11.3 The CONTRACTOR shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.

2.30.11.4 The CONTRACTOR shall submit its annual reevaluation of accreditation status based on HEDIS scores immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.

2.30.11.5 The CONTRACTOR shall submit an annual *Report of Audited CAHPS Results* and *Audited HEDIS Results* by June 15 of each year (see Sections 2.15.6 and 2.15.7). This shall include the results for the CAHPS survey for CHOICES members, which shall include the Medicare CAHPS questions specified by TENNCARE (see Section 2.15.6).

2.30.11.6 The CONTRACTOR shall submit survey data files for the Health Outcomes Survey (HOS) (see Section 2.15.7).

2.30.11.7 The CONTRACTOR shall submit a quarterly *Critical Incidents Report* (see Section 2.15.8) that provides current information, by month, as well as cumulative information regarding specified measures and a summary report.

The performance measures shall include but not be limited to the following:

(1) The number of critical incidents, overall and by:
   (a) Type
   (b) CHOICES Group
   (c) Setting
   (d) Type of provider (agency or worker)
   (e) Provider

(2) Of all critical incidents, the percent that were reported to the CONTRACTOR within the specified timeframes

(3) The number of investigations conducted by a provider agency, overall and by type of incident

(4) The number of investigation reports reviewed by the CONTRACTOR, overall and by type of incident

(5) The number of incidents reported to APS/CPS

(6) The number of investigations conducted by APS/CPS (to the extent this information is available)

(7) The number of investigations conducted by the FEA

(8) The number of investigations conducted by an entity other than the provider, FEA, or APS/CPS, and the name of that entity

The CONTRACTOR shall provide information on each of these measures by and across previous quarters on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The summary report shall include identification of any trends and any action steps to reduce the number of critical incidents and improve the critical incident reporting and management process.

2.30.12 **Customer Service Reports/Provider Service Reports**

2.30.12.1 Member Services/Provider Services/ED Phone Line Reports

2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services and Provider Services Phone Line Report.* The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

2.30.12.1.2 The CONTRACTOR shall submit a quarterly *24/7 Nurse Triage Line Report* that lists the total calls received by the 24/7 nurse triage line, including the number of calls from CHOICES members, including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care, transfers to a care coordinator (for CHOICES members). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2.18.4.7 of this Agreement, such calls shall be separately delineated in the report in accordance with the requirements described in Section 2.30.12.1.3 of this Agreement.

2.30.12.1.3 The CONTRACTOR shall submit a quarterly *ED Assistance Tracking Report* that provides the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report shall include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the nurse triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2.30.12.1.2.

2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement (see Section 2.18.7.4).

2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone, by type of provider, and the disposition/resolution of those complaints. The data shall be reported by month.

2.30.13 **Member Complaints**

The CONTRACTOR shall submit a quarterly *Member Complaints Report* (see Section 2.19.2) that includes current information, by month, as well as cumulative information regarding specified measures, an exceptions report (as needed), a cumulative report, a summary report, and a performance improvement plan (as applicable).

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following:

(1) The number of complaints received in the month, overall, by type, and by CHOICES Group (if the member is a CHOICES member)

(2) The number and percent of complaints received in the month, overall and by CHOICES Group (if applicable), that were/were not resolved within five (5) business days via a call with the member (see Section 2.19.2)

(3) Of complaints that were not resolved within five (5) business days via a call with the member and for which resolution is due, the number and percent of complaints for which the CONTRACTOR met/did not meet the specified timeframe for resolution and notice of resolution (see Section 2.19.2.5)

(4) Of complaints that were not resolved within five (5) business days via a call with the member, the minimum, maximum, median, and average amount of time that the CONTRACTOR took to resolve complaints and notify members of resolution

Starting the thirteenth month after CHOICES implementation, the performance measures shall include but not be limited to the performance measures from the first twelve (12) month as well as the following performance measure:

(1) Of complaints that were not resolved within five (5) business days via a call with the member and for which acknowledgement is due, the number and percent for which the CONTRACTOR met/did not meet the specified timeframe for sending a notice of acknowledgement (see Section 2.19.2.5)

If the CONTRACTOR's performance for any one of the timeframe measures is less than one hundred percent (100%), the CONTRACTOR shall provide an exceptions report for that measure. The report shall identify the number and percent of members for whom the CONTRACTOR did not meet the specified timeframe and provide detail information regarding each instance in which the CONTRACTOR did not meet the applicable timeframe. The detail information shall include but not be limited to for each member: the date the applicable activity should have occurred, the actual date that the applicable activity occurred (if it occurred within the reporting period), the date that the applicable activity will occur (if it did not occur within the reporting period), and why the CONTRACTOR exceeded the timeframe.

Each quarterly report shall also include a cumulative report that includes: (1) a follow-up exceptions report that provides updated information on the exceptions reported in the previous report that identifies any members for whom the CONTRACTOR did not remediate on the date specified in the previous exceptions report; (2) for each month in the previous twelve (12) months, for each timeframe measure, the CONTRACTOR's performance; (3) over the previous months, on a rolling twelve (12) month basis, for each timeframe measure, the minimum,

maximum, median, and average amount of time that it took the CONTRACTOR to complete the applicable activity, which shall include instances where the activity was completed after the specified timeframe, as compared to the timeframe specified in this Agreement for that measure; and (4) for any non-timeframe measures, the information by and across previous months on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The summary report shall also include identification of any trends regarding complaints (e.g., the type or number of complaints) and any action steps to address these trends, including quality improvement activities.

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter after CHOICES implementation.

If the CONTRACTOR's failure to meet the timeframes is systemic, as determined by the CONTRACTOR or TENNCARE, the CONTRACTOR shall submit a performance improvement plan that includes an analysis of the reasons for non-compliance, actions taken/to be taken by the CONTRACTOR to ensure compliance, the timeframes for these actions, who is responsible for the actions, and any related quality improvement activities, including timeframes.

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.

2.30.15 **Financial Management Reports**

2.30.15.1 <u>Third Party Liability (TPL) Resources Reports</u>

2.30.15.1.1 The CONTRACTOR shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE.

2.30.15.1.2 The CONTRACTOR shall submit an *Other Insurance Report* that provides information on any members who have other insurance, including long-term care insurance. This report shall be submitted in a format and frequency described by TENNCARE.

2.30.15.2 Patient Liability Reports

The CONTRACTOR shall submit a quarterly *CHOICES Patient Liability Report* that provides, for any members for whom the CONTRACTOR is aware that the full patient liability amount was not collected by a nursing facility provider, the efforts taken by the CONTRACTOR/nursing facility to collect any unpaid amounts, identified issues, and strategies to address issues, both on an individual basis for those members who have not paid their complete patient liability amount and systemically.

2.30.15.3 Financial Reports to TENNCARE

2.30.15.3.1 The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.16.3 and 2.23.4.

2.30.15.3.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.9 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

2.30.15.3.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year (see Section 2.30.48).

2.30.15.4 TDCI Financial Reports

2.30.15.4.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report.* This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Agreement. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.

2.30.15.4.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report*. If necessary, the CONTRACTOR shall revise the calendar year budget based

on its actual results of operations. Any revisions to the budget shall include narratives explaining the assumptions and calculations utilized in making the revisions.

2.30.15.4.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-208. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report shall also be accompanied by the Medical Loss Ratio report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Loss Ratio report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).

2.30.15.4.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report.* These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on September 1) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

2.30.15.4.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements.* Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:

2.30.15.4.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.

2.30.15.4.5.2 Any requests for extension of the May 1 submission date must be granted by the Office of the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

2.30.15.4.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

2.30.16 **Claims Management Reports**

2.30.16.1 The CONTRACTOR shall submit a monthly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section 2.22.6) and shall report on the number and percent of claims that are paid accurately. As provided in Section 2.22.6.6, if the CONTRACTOR subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor shall include the results of the internal audit conducted in compliance with Section 2.22.6 and shall report on the number and percent of claims that are paid accurately.

2.30.16.2 The CONTRACTOR shall submit a quarterly *Explanation of Benefits* (*EOB) Report*. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section 2.22.8.)

2.30.16.3 The CONTRACTOR shall submit a weekly *Claims Activity Report.* This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, and total amount paid by the categories of service specified by TENNCARE.

2.30.16.4 The CONTRACTOR shall submit a quarterly *HCBS Annual Benefit Limits Report* that provides information on CHOICES members in Group 2 or 3 who are approaching or have met an annual benefit limit for HCBS. The report shall provide current and cumulative information regarding specified measures, including but not limited to the following:

(1) The number and percent of members in Group 2 who are within specified percentages of an annual benefit limit, by service

(2) The number and percent of members in Group 2 who have met an annual benefit limit, by specified timeframes, overall and by service

In addition, upon implementation of Group 3, the performance measures shall include but not be limited to the following:

(1) The number and percent of members in Group 3 who are within specified percentages of an annual benefit limit, by service

(2) The number and percent of members in Group 3 who have met an annual benefit limit, overall and by service

The report shall also include assurance to TENNCARE that the CONTRACTOR (a) has notified each member who is approaching an annual HCBS benefit limit that he/she is approaching the limit and (b) has sent a notice to each member (pursuant to TennCare rules and regulations) who has requested services in excess of a specified annual benefit limit and for whom the CONTRACTOR will not provide services in excess of the limit as a CEA.

The CONTRACTOR shall submit its first report following the third calendar quarter after CHOICES implementation, and that report shall include information from the date of CHOICES implementation through the third calendar quarter.

2.30.16.5 The CONTRACTOR shall submit a quarterly *Cost Neutrality Report* that provides information, by month, on members in CHOICES Group 2 who are approaching or have met the cost neutrality cap for CHOICES members in Group 2. The report shall provide current information, by month, as well as cumulative information regarding specified measures.

The performance measures for the first twelve (12) months after CHOICES implementation shall include but not be limited to the following

(1) The number and percent of members in Group 2 who are within specified percentages of the member's cost neutrality cap, on a monthly and/or annual basis

(2) The number and percent of members in Group 2 who are projected to exceed their cost neutrality cap, on a monthly and/or annual basis, by specified timeframes

Starting the thirteenth month after CHOICES implementation, the performance measures shall include but not be limited to the performance measures from the first twelve (12) month as well as the following performance measure:

(1) Of the members in Group 2 who were projected to exceed their cost neutrality cap, the number and percent whose plan of care was revised to remain within the cap

(2) The number of members in Group 2 for whom the CONTRACTOR has determined that the member's needs can no longer be safely and effectively met within the cost neutrality cap and should be enrolled in Group 1

(3) Of the members in Group 2 for whom the CONTRACTOR determined that the member's needs can no longer be safely and effectively met within the cost neutrality cap and should be enrolled in Group 1, the number and percent who enrolled in Group 1

(4) Of the members in Group 2 for whom the CONTRACTOR determined that the member's needs can no longer be safely and effectively met within the cost neutrality cap and should be enrolled in Group 1, the number and percent who declined to enroll in Group 1

The report shall include assurance to TENNCARE that the CONTRACTOR has notified each member who is projected to meet his/her cost neutrality cap that he/she is projected to meet his/her cost neutrality cap and informed the member of his/her options.

2.30.16.6 Upon implementation of CHOICES Group 3, the CONTRACTOR shall submit a quarterly *Expenditure Cap Report* that provides information on members in CHOICES Group 3 who are approaching or have met the expenditure cap (see

Section 2.6.1.5.5). The report shall provide current and cumulative information regarding specified measures, including but not limited to the following:

(1) The number and percent of members in Group 3 who are within specified percentages of the expenditure cap

(2) The number and percent of members in Group 3 who have met the expenditure cap

The cumulative information shall include information on each of these measures by and across previous quarters on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The report shall also include assurance to TENNCARE that (a) the CONTRACTOR has notified each member who is projected to meet the expenditure cap that he/she is projected to meet the expenditure cap and informed the member of what will happen when he/she meets the expenditure cap; and (2) has sent a notice to each member (pursuant to TennCare rules and regulations) who has requested services in excess of the expenditure cap.

2.30.16.7 The CONTRACTOR shall submit a quarterly *Cost Effective Alternative Services for CHOICES Report* that provides information on cost effective alternative services provided to CHOICES members (see Section 2.5.5.3). The report shall provide current and cumulative information regarding specified measures, including but not limited to the following:

(1) The number and percent of members in Group 2 who were enrolled in Group 2 as a CEA

(2) The minimum, maximum, median, and average amount that members, overall and by Group 2 and 3, have exceeded a benefit limit as a CEA, by service

(3) The number and percent of members, overall and by Group 2 and 3, who receive non-covered HCBS as a CEA, by non-covered HCBS

(4) The number and percent of members transitioning from a nursing facility to the community who used a transition allowance as a CEA

The cumulative information shall include information on each of these measures by and across previous quarters on a rolling twelve (12) month basis. The report shall include a graphical representation of current and cumulative information.

The CONTRACTOR shall submit its first report following the second calendar quarter after CHOICES implementation, and that report shall include information for the period from CHOICES implementation through the second calendar quarter.

2.30.17 **Information Systems Reports**

2.30.17.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section 2.23.1.6.

2.30.17.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section 2.23.4) and transmitted electronically to TENNCARE on a weekly basis.

2.30.17.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section 2.30.15.3.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the MLR report.

2.30.17.4 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.

2.30.17.5 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the CONTRACTOR's span of control.

2.30.17.6 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TENNCARE. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and written approval by TENNCARE.

2.30.18 **Administrative Requirements Reports**

2.30.18.1 The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee* regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

2.30.18.2 The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's CHOICES Advisory Group* regarding the activities of the CHOICES advisory group established pursuant to Section 2.24.3. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

2.30.19 **Subcontract Reports**

2.30.19.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-

affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.

2.30.19.2 In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

2.30.19.2.1 *General Controls*

2.30.19.2.1.1 Personnel Policies

2.30.19.2.1.2 Segregation of Duties

2.30.19.2.1.3 Physical Access Controls

2.30.19.2.1.4 Hardware and System Software

2.30.19.2.1.5 Applications System Development and Modifications

2.30.19.2.1.6 Computer Operations

2.30.19.2.1.7 Data Access Controls

2.30.19.2.1.8 Contingency and Business Recovery Planning

2.30.19.2.2 *Application Controls*

2.30.19.2.2.1 Input

2.30.19.2.2.2 Processing

2.30.19.2.2.3 Output

2.30.19.2.2.4 Documentation Controls

2.30.20 **HIPAA Reports**

The CONTRACTOR shall submit a *Privacy/Security Incident Report*. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

2.30.21 **Non-Discrimination Compliance Reports**

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

2.30.21.2 The CONTRACTOR shall submit a quarterly *Supervisory Personnel Report* that contains a summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE.

2.30.21.3 The CONTRACTOR shall submit a quarterly *Alleged Discrimination Report*. The report shall include a listing of all complaints alleging discrimination filed by employees, members, providers and subcontractors in which discrimination is alleged by the CONTRACTOR's MCO. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint.

2.30.21.4 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in provision of services to members with Limited English Proficiency. This shall include a report that lists all interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, and hours services are available.

2.30.21.5 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan* and *Assurance of Non-Discrimination* to TENNCARE. The signature date of the

CONTRACTOR's Title VI Compliance Plan shall coordinate with the signature date of the CONTRACTOR's Assurance of Non-Discrimination.

2.30.22 **Terms and Conditions Reports**

2.30.22.1 Quarterly, by January 30, April 30, July 30, and October 30 each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section 4.19.

2.30.22.2 Pursuant to Section 4.34.2, on a semi-annual basis the CONTRACTOR shall submit the attestation in Attachment X.

27. Section 2.31 shall be deleted in its entirety.

28. Section 3 shall be deleted in its entirety and replaced with the following:

SECTION 3 - PAYMENTS TO THE CONTRACTOR

3.1 GENERAL PROVISIONS

3.1.1 TENNCARE shall make monthly payments to the CONTRACTOR for its satisfactory performance and provision of covered services under this Agreement. Capitation rates shall be paid according to the methodology as described in this Agreement.

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, any incentive payments (if applicable) and any payments that offset the CONTRACTOR's cost for the development and implementation of an electronic visit verification system (EVV) (see Section 3.13) are payment in full for all services provided pursuant to this Agreement. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at TCA 56-32-101 *et seq*. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at TCA 56-51-101 *et seq*. or any subsequent amendments thereto. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

3.2 ANNUAL ACTUARIAL STUDY

In accordance with TCA 71-5-188, the State will retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE in order to assist the State's actuary with completion of the annual actuarial study.

3.3 CAPITATION PAYMENT RATES

3.3.1 The CONTRACTOR will be paid a base capitation rate for each enrollee based on the enrollee's rate category. Rate categories are based on various factors, including the enrollee's enrollment in CHOICES, category of aid, age/sex combination and the Grand Region served by the CONTRACTOR under this Agreement. The rate categories and the specific rates associated with each rate category are specified in Attachment XII.

3.3.2 The major aid categories are as follows:

3.3.2.1 Medicaid;

3.3.2.2 Uninsured/Uninsurable;

3.3.2.3 Disabled - The disabled rate is only for those enrollees who are eligible for Medicaid as a result of a disability; and

3.3.2.4 Duals/Waiver Duals - For the purpose of capitation rates, Duals/Waiver Duals are TennCare Medicaid or TennCare Standard enrollees who have Medicare eligibility.

3.3.3 The CONTRACTOR will also be paid a priority add-on rate for behavioral health services in accordance with the rates specified in Attachment XII for each priority enrollee. The CONTRACTOR will be paid the priority add-on rate for priority enrollees, as defined in this Agreement, who have received behavioral health services as reported pursuant to Section 2.23.4 of this Agreement, within the preceding twelve (12) months from the date of the calculation of the monthly payment, and who have had a valid CRG/TPG assessment within the preceding twelve (12) months from the date of the calculation of the monthly payment.

3.3.4 TENNCARE will determine the appropriate rate category to which each enrollee is assigned for payment purposes under this Agreement.

3.3.5 TENNCARE's assignment of an enrollee to a rate category is for payment purposes under this Agreement, only, and is not an "adverse action" or determination of the benefits to which an enrollee is entitled under the TennCare program, TennCare rules and regulations, TennCare policies and procedures, the TennCare waiver or relevant court orders or consent decrees.

3.4 CAPITATION RATE ADJUSTMENT

3.4.1 The CONTRACTOR and TENNCARE agree that the capitation rates described in Section 3 of this Agreement may be adjusted periodically.

3.4.2 The CONTRACTOR and TENNCARE further agree that adjustments to capitation rates shall occur only by written notice from TENNCARE to the CONTRACTOR. The notice will be given at least thirty (30) calendar days before the new rates come into effect. Should the CONTRACTOR refuse to continue this Agreement under the new rates, the CONTRACTOR then may activate the Termination provisions contained in Section 4.4.7 of this Agreement. During the six (6) month Termination Notice period the CONTRACTOR will continue to be paid under the new rates. In the event the CONTRACTOR indicates that it is refusing to accept the new rates, but does not choose to institute Termination proceedings under Section 4.4.7 of this Agreement then the State may at its option:

3.4.2.1 Declare that a public exigency exists under Section 4.2.3 of this Agreement. If the State makes this declaration the CONTRACTOR will continue to be paid under the new rates,

3.4.2.2 Declare that the contract is Terminated for Convenience under the provisions of Section 4.4.6 of this Agreement. If the State makes this declaration the CONTRACTOR will continue to be paid under the new rates for the period of time until the Termination date.

3.4.3 The base capitation rates shall be adjusted by the State for health plan risk in accordance with the following:

3.4.3.1 Health plan risk assessment scores will be initially recalibrated after current TennCare enrollees are assigned to the MCOs for retroactive application to payment rates effective on the start date of operations. This initial recalibration will be based upon the distribution of enrollment on the start date of operations and health status information will be 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.

3.4.3.2 In the initial recalibration, 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 original base capitation rates will be proportionally adjusted.

3.4.3.3 Thereafter, 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.

3.4.3.4 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, defined as a change of three percent (3%) or more, whether a negative or positive change in scores, TENNCARE may adjust the original base capitation rates as subsequently adjusted for all MCOs.

3.4.3.5 In addition to the annual recalibration of risk adjustment factors, those factors will be updated when there is a significant change in program participation. This may occur when an MCO enters or leaves a Grand Region. If an MCO withdraws from a Grand Region, that MCO's membership may be temporarily distributed to TennCare Select or distributed to the remaining MCOs or to new MCOs. New risk adjustment values for the remaining MCOs or new MCO(s) will be calculated that consider the population that will be enrolled in the MCO for the remainder of the contract year only. In this instance, MCOs would be given the option to provide TENNCARE, in writing, with a six (6) months notice of termination in accordance with Section

4.4.7.2. This notice option is not available for rate adjustments as described in Sections 3.4.3.1 through 3.4.3.4.

3.4.3.6 An individual's health status will be determined using the John Hopkins ACG® Case-Mix System (ACG System). In the event the State elects to use a different system to calculate an adjustment for MCO health status risk, the State will notify the CONTRACTOR prior to its implementation. The ACG System does not account for long-term care services or service delivery setting.

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.

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.

3.4.5 If (i) changes are required pursuant to federal or state statute, federal regulations, the action of a federal agency, a state or federal court, or rules and regulations of a State of Tennessee agency other than the TennCare Bureau and (ii) the changes are likely to impact the actuarial soundness of the capitation rate(s) described in Section 3, as determined by TENNCARE, TENNCARE shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.6 In the event TENNCARE amends TennCare rules or regulations or initiates a policy change not addressed in Section 3.4.5 above that is likely to impact the capitation rate(s) described in Section 3, as determined by TENNCARE, TENNCARE shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.7 In the event the amount of the two percent (2%) premium tax is increased during the term of this Agreement, the payments shall be increased by an amount equal to the increase in premium payable by the CONTRACTOR.

3.4.8 Any rate adjustments shall be subject to the availability of state appropriations.

3.5 CAPITATION PAYMENT SCHEDULE

TENNCARE shall make payment by the fifth (5th) business day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement.

3.6 CAPITATION PAYMENT CALCULATION

3.6.1 When eligibility has been established by the State for enrollees, the amount owed to the CONTRACTOR shall be calculated as described herein.

3.6.2 Each month payment to the CONTRACTOR shall be equal to the number of enrollees enrolled in the CONTRACTOR's MCO five (5) business days prior to the date of the capitation payment multiplied by the appropriate capitation rate(s) for the enrollee.

3.6.3 The capitation rates stated in Attachment XII will be the amounts used to determine the amount of the monthly capitation payment.

3.6.4 The actual amount owed the CONTRACTOR for each member shall be determined by dividing the appropriate monthly capitation rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the CONTRACTOR's MCO.

3.6.5 The amount paid to the CONTRACTOR shall equal the total of the amount owed for all enrollees determined pursuant to Section 3.6.4 less the withhold amount (see Section 3.9), capitation payment adjustments made pursuant to Section 3.7 or 3.11, and any other adjustments, which may include withholds for penalties, damages, liquidated damages, or adjustments based upon a change of enrollee status.

3.7 CAPITATION PAYMENT ADJUSTMENTS

3.7.1 The State has the discretion to retroactively adjust the capitation payment for any enrollee if TENNCARE determines an incorrect payment was made to the CONTRACTOR; provided, however:

3.7.1.1 For determining the capitation rate(s) only, the Grand Region being served by the enrollee's MCO under this Agreement will be used to determine payment. The capitation payment shall not be retroactively adjusted to reflect a different Grand Region of residence so long as the enrollee's MCO assignment is effective.

3.7.1.2 For individuals enrolled with a retroactive effective date on the date of enrollment, the payment rate for retroactive periods shall be the capitation rate(s) for the applicable rate category and the Grand Region in which the enrollee's assigned MCO is operating under this Agreement as specified in Attachment XII, except that:

3.7.1.2.1 The CONTRACTOR agrees to manually process claims and reimburse providers for services incurred prior to the start date of operations of this Agreement; however, the CONTRACTOR will not be at risk for these services. The CONTRACTOR shall be paid two dollars ($2.00) per claim as reimbursement for processing claims for services incurred prior to the start date of operations. Actual expenditures for covered services and the allowed amount for claims processing are subject to TCA 56-32-124. The CONTRACTOR shall negotiate provider reimbursement subject to TENNCARE prior written approval and prepare checks for payment of providers for the provision of covered services incurred during an enrollee's period of eligibility prior to the start date of operations on an as needed basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and format at least forty-eight

(48) hours in advance of distribution of any provider payment related to this requirement. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, two dollars ($2.00) per claim processed by the CONTRACTOR; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-124 within forty-eight (48) hours of receipt of notice. The CONTRACTOR shall then release payments to providers within twenty-four (24) hours of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-124.

3.7.1.2.2 TENNCARE will be responsible for the payment of claims for long-term care services provided to a CHOICES member during the member's period of eligibility prior to the implementation of CHOICES in the Grand Region covered by this Agreement.

3.7.1.3 If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the CONTRACTOR shall assess cost sharing responsibilities in accordance with the cost sharing schedules in effect on the date of service for which reimbursement is sought (see Attachment II) and collect patient liability from CHOICES members as applicable (see Sections 2.6.7.2 and 2.21.5).

3.7.1.4 Should TENNCARE determine after the capitation payment is made that an enrollee's capitation rate category had changed or the enrollee was deceased, TENNCARE shall retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period for which payment has been made. TENNCARE shall initially retroactively adjust the payment to the CONTRACTOR, not to exceed twelve (12) months. Subsequently, TENNCARE shall further retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period prior to the twelve (12) month adjustment initially made by TENNCARE. TENNCARE will make the subsequent adjustment at least semi-annually.

3.7.1.4.1 TENNCARE and the CONTRACTOR agree that the twelve (12) month limitation described in Sections 3.7.1.4 is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the CONTRACTOR's MCO.

3.7.1.5 Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process.

3.8 SERVICE DATES

Except where required by this Agreement or by applicable federal or state law, the CONTRACTOR shall not make payment for the cost of any services provided prior to the effective date of eligibility in the CONTRACTOR's MCO. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's MCO.

3.9 WITHHOLD OF THE CAPITATION RATE

3.9.1 A withhold of the aggregate capitation payment shall be applied to ensure CONTRACTOR compliance with the requirements of this Agreement and to provide an agreed incentive for assuring CONTRACTOR compliance with the requirements of this Agreement.

3.9.2 The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section 3.6 shall be reduced by the appropriate cash flow withhold percentage amount and set aside for distribution to the CONTRACTOR in the next regular monthly payment, unless retained as provided below.

3.9.2.1 Except as further provided below, the applicable capitation payment withhold amount will be equivalent to ten percent (10%) of the monthly capitation payment for the first six months following the start date of operations, and for any consecutive six (6) month period following the CONTRACTOR's receipt of a notice of deficiency as described in Section 2.25.9;

3.9.2.2 If, during any consecutive six (6) month period following the start date of operations, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to five percent (5%) of the monthly capitation payment.

3.9.2.3 If, during any consecutive six (6) month period following a reduction of the monthly withhold amount to five percent (5%) of the monthly capitation payment, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to two and one half percent (2.5%) of the monthly capitation payment.

3.9.2.4 If the CONTRACTOR is notified by TENNCARE of a minor deficiency and the CONTRACTOR cures the minor deficiency to the satisfaction of TENNCARE within a reasonable time prior to the next regularly scheduled capitation payment cycle, TENNCARE may disregard the minor deficiency for purposes of determining the withhold.

3.9.2.5 If TENNCARE has determined the CONTRACTOR is not in compliance with a requirement of this Agreement in any given month, TENNCARE will issue a written notice of deficiency and TENNCARE will retain the amount withheld for the month prior to TENNCARE identifying the compliance deficiencies.

3.9.2.6 The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies shall be in accordance with Section 3.9.2.1 as described above. If the CONTRACTOR has attained a two and one half percent (2.5%) withhold and TENNCARE subsequently determines the CONTRACTOR is not in compliance with a requirement of this Agreement, TENNCARE will provide written notice of such determination and TENNCARE will re-institute the retention of the withhold as described in Section 3.9.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount will continue for each subsequent month so long as the identified deficiencies have not been corrected. These funds will not be distributed to the CONTRACTOR unless it is determined by TENNCARE the CONTRACTOR has come into compliance with the Agreement requirement(s) within six (6) months of TENNCARE identifying these deficiencies.

For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies which the CONTRACTOR has been given written notice of by TENNCARE, the withhold for the four (4) consecutive months will be paid to the CONTRACTOR upon TENNCARE determination that the deficiency(s) was corrected. However, any amounts withheld by TENNCARE for six (6) consecutive months for the same or similar compliance deficiency(s) shall be retained by TENNCARE on the anniversary of the sixth consecutive month and shall not be paid to the CONTRACTOR. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TENNCARE may declare the MCO ineligible for future distribution of the ten percent (10%) incentive withhold. Such ineligibility will continue for each month TENNCARE determines the same or similar specified deficiency(s) continues to exist. Once a CONTRACTOR corrects the deficiency(s), TENNCARE may reinstate the MCO's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TENNCARE determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the CONTRACTOR.

3.9.3 No interest shall be due to the CONTRACTOR on any sums withheld or retained under this Section. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Agreement.

3.9.4 If TENNCARE has not identified CONTRACTOR deficiencies, TENNCARE will pay to the CONTRACTOR the withhold of the CONTRACTOR's payments withheld in the month subsequent to the withhold.

3.10 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

3.10.1 General

3.10.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 3.10.

3.10.1.2 Pursuant to 42 CFR 438.6, the total of all payments made to the CONTRACTOR for a year shall not exceed one hundred and five percent (105%) of capitation payments made to the CONTRACTOR.

3.10.1.3 In the first year that the incentives specified in Sections 3.10.2 and 3.10.3 below are available, the TennCare regional average HEDIS score (as calculated by TENNCARE using audited MCO HEDIS results) for each of the measures specified in Sections 3.10.2 and 3.10.3 for the last full calendar year prior to the year that the CONTRACTOR began operating under this Agreement will serve as the baseline. If complete TennCare HEDIS data for these measures is not available for the region for the year prior to the year that the CONTRACTOR began operating under this Agreement, then the last year for which complete data is available will serve as the baseline.

3.10.1.4 If NCQA makes changes in any of the measures specified in Section 3.10.2 or 3.10.3 below, such that valid comparison to prior years will not be possible, TENNCARE, at its sole discretion, may elect to either eliminate the measure from pay-for-performance incentive eligibility or replace it with another measure.

3.10.2 **Physical Health HEDIS Measures**

3.10.2.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 3.10.2.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR's HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below).

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

3.10.2.2.1 HbA1C Testing – Diabetes measure;

3.10.2.2.2 HbA1C Control – Diabetes measure;

3.10.2.2.3 LDL-C Screening Performed – Diabetes measure;

3.10.2.2.4 Adolescent Well-Care Visits;

3.10.2.2.5 Breast Cancer Screening; and

3.10.2.2.6 Controlling High Blood Pressure.

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

3.10.3 **Behavioral Health HEDIS Measures**

3.10.3.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. The CONTRACTOR's HEDIS result for the reporting period prior to the current reporting period will serve as the baseline. To be eligible for incentive payment for a measure, the CONTRACTOR must demonstrate significant improvement for both rates comprising the measure. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below).

3.10.3.1.1 Antidepressant Medication Management; and

3.10.3.1.2 Follow-up Care for Children Prescribed ADHD Medication.

3.10.4 **Community Tenure/Hospital Readmission for Mental Illness**

3.10.4.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, if significant improvement has been demonstrated in the rate at which members hospitalized for mental illness remain in the community (i.e. are not readmitted to an inpatient hospital setting for treatment of mental illness) within thirty (30) days of discharge. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below). The baseline rate will be the percentage of the CONTRACTOR's enrollees that were discharged following hospitalization for mental illness during the reporting period prior to the current reporting period and that were not readmitted within thirty (30) days following discharge, as calculated by TennCare. The baseline rate will be compared to the percentage of the CONTRACTOR's members that were discharged following hospitalization for mental illness during the preceding calendar year of operation, and that were not readmitted within thirty (30 days) following discharge. The latter calculation will use methodology identical to that used in the baseline calculation performed by TENNCARE.

3.10.5 **NCQA Minimum Effect Size Change Methodology**

The NCQA minimum effect size change methodology is as follows:

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

3.11 EFFECT OF DISENROLLMENT ON CAPITATION PAYMENTS

3.11.1 Payment of capitation payments shall cease effective the date of the member's disenrollment from the CONTRACTOR's MCO, and the CONTRACTOR shall have no further responsibility for the care of the enrollee. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively.

3.11.2 **Fraudulent Enrollment**

3.11.2.1 In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TENNCARE all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the CONTRACTOR's MCO.

3.11.2.2 In the event of enrollment obtained by fraud, misrepresentation or deception by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors,

or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the CONTRACTOR for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

3.12 HMO PAYMENT TAX

The CONTRACTOR shall be responsible for payment of applicable taxes pursuant to TCA 56-32-124. In the event the amount due pursuant to TCA 56-32-124 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

3.13 PAYMENTS TO THE CONTRACTOR FOR ELECTRONIC VISIT VERIFICATION SYSTEM

TENNCARE will pay the CONTRACTOR $605,600 to offset the CONTRACTOR's costs related to implementing an electronic visit verification (EVV) system. In accordance with the applicable appropriations language, these funds shall be used to implement the EVV, and they shall not be used for any other purpose. Upon TENNCARE's request the CONTRACTOR shall submit documentation that demonstrates that funds were used to offset the CONTRACTOR's costs related to implementing the EVV.

3.14 PAYMENT TERMS AND CONDITIONS

3.14.1 Maximum Liability

3.14.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed two billion, three hundred fifty six million, seven hundred forty three thousand, eight hundred seventy one dollars ($2,356,743,871.00).

3.14.1.2 If the Agreement maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment pursuant to Section 3.4 above, the State shall adjust the Agreement maximum liability to accommodate the aforementioned circumstances. This adjustment shall be based on consultation with the State's independent actuary.

3.14.1.3 This Agreement does not obligate the State to pay a fixed minimum amount and does not create in the CONTRACTOR any rights, interests or claims of entitlement in any funds.

3.14.1.4 The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Agreement or any extensions of the Agreement. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of these funds to the CONTRACTOR under this Agreement.

3.14.2 **Compensation Firm**

The capitation rates and the Maximum Liability of the State under this Agreement are firm for the duration of the Agreement and are not subject to escalation for any reason unless amended, or changed by the Notice specified in Section 3.4.2 of this Agreement.

3.14.3 **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, 2008 for all non-CHOICES rate categories will be established through a competitive bid process, and the priority add-on rate and the base capitation rate for CHOICES members will be established by the State. The base capitation rates (for CHOICES and non-CHOICES members) and the priority add-on rate for subsequent years will be set by Notice as provided under Section 3.4.2 of this Agreement.

3.14.4 **Payment Methodology**

The CONTRACTOR shall be compensated in accordance with Section 3 above as authorized by the State in a total amount not to exceed the Agreement Maximum Liability established in Section 3.13.1 above. The CONTRACTOR's compensation shall be contingent upon the satisfactory completion of requirements under this Agreement.

3.14.5 **Return of Funds and Deductions**

3.14.5.1 The CONTRACTOR shall refund to TENNCARE any overpayments due or funds disallowed pursuant to this Agreement within thirty (30) calendar days of the date of written notification from TENNCARE, unless otherwise authorized by TENNCARE in writing.

3.14.5.2 The State reserves the right to deduct from amounts which are or shall become due and payable to the CONTRACTOR under this or any Agreement or contract between the CONTRACTOR and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the CONTRACTOR.

3.14.6 **Automatic Deposits**

The CONTRACTOR shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits)" form. This form shall be provided to the CONTRACTOR by the State. Once this form has been completed and submitted to the State by the CONTRACTOR all payments to the CONTRACTOR, under this or any other Agreement/contract the CONTRACTOR has with the State of Tennessee shall be made by Automated Clearing House (ACH). The CONTRACTOR shall not be paid under this Agreement until the CONTRACTOR has completed this form and submitted it to the State.

29. Sections 4.2 through 4.5 shall be deleted in their entirety and replaced with the following:

4.2 AGREEMENT TERM

4.2.1 **Term of the Agreement**

This Agreement, including any amendments and any changes made by notice to adjust the capitation rates, shall be effective commencing on August 15, 2006 and ending on June 30, 2010.

4.2.2 **Term Extension**

The State reserves the right to extend this Agreement for an additional period or periods of time representing increments of no more than one (1) year and a total term of no more than five (5) years, provided that the State notifies the CONTRACTOR in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. An extension of the term of this Agreement will be effected through an amendment to the Agreement.

4.2.3 **Exigency Extension**

4.2.3.1 At the option of the State, the CONTRACTOR agrees to continue services under this Agreement when TENNCARE determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days written notice shall be given by TENNCARE before this option is exercised.

4.2.3.2 A written notice of exigency extension shall constitute an amendment to the Agreement, may include a revision of the maximum liability and other adjustments permitted under Section 3, and shall be approved by the F&A Commissioner and the Office of the Comptroller of the Treasury.

4.2.3.3 During any periods of public exigency, TENNCARE shall continue to make payments to the CONTRACTOR as specified in Section 3 of this Agreement.

4.3 APPLICABLE LAWS AND REGULATIONS

The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, policies (including TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the CONTRACTOR pursuant to this Agreement)), consent decrees, and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

4.3.1 42 CFR Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4.3.2 45 CFR Part 74, General Grants Administration Requirements.

4.3.3 Titles 4, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the TennCare Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.

4.3.4 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 USC 7401, *et seq*.).

4.3.5 Title VI of the Civil Rights Act of 1964 (42 USC 2000d) and regulations issued pursuant thereto, 45 CFR Part 80.

4.3.6 Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment.

4.3.7 Section 504 of the Rehabilitation Act of 1973, 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84.

4.3.8 The Age Discrimination Act of 1975, 42 USC 6101 *et seq*., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

4.3.9 The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

4.3.10 Americans with Disabilities Act, 42 USC 12101 *et seq*., and regulations issued pursuant thereto, 28 CFR Parts 35, 36.

4.3.11 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare, SCHIP and/or Medicaid program.

4.3.12 Tennessee Consumer Protection Act, TCA 47-18-101 *et seq*.

4.3.13 The TennCare Section 1115 waiver and all Special Terms and Conditions which relate to the waiver.

4.3.14 Executive Orders, including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003.

4.3.15 The Clinical Laboratory Improvement Amendments (CLIA) of 1988.

4.3.16 Requests for approval of material modification as provided at TCA 56-32-201 *et seq*.

4.3.17 Investigatory Powers of TDCI pursuant to TCA 56-32-232.

4.3.18 42 USC 1396 *et seq*. (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4.3.19 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.

4.3.20 Title IX of the Education Amendments of 1972 regarding education programs and activities.

4.3.21 Title 42 CFR 422.208 and 210, Physician Incentive Plans.

4.3.22 Equal Employment Opportunity (EEO) Provisions.

4.3.23 Copeland Anti-Kickback Act.

4.3.24 Davis-Bacon Act.

4.3.25 Contract Work Hours and Safety Standards.

4.3.26 Rights to Inventions Made Under a Contract or Agreement.

4.3.27 Byrd Anti-Lobbying Amendment.

4.3.28 Subcontracts in excess of one hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

4.3.29 Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P. L. 94-165.)

4.3.30 TennCare Reform Legislation signed May 11, 2004.

4.3.31 Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

4.3.32 Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

4.3.33 Title 33 (Mental Health Law) of the Tennessee Code Annotated.

4.3.34 Rules of the Tennessee Department of Mental Health and Developmental Disabilities, Rule 0940 *et seq*.

4.3.35 Section 1902(a)(68) of the Social Security Act regarding employee education about false claims recovery.

4.3.36 TennCare rules and regulations.

4.3.37 TCA 3-6-101 *et seq*., 3-6-201 *et seq*., 3-6-301 *et seq*., and 8-50-505.

4.3.38 TCA 71-6-101 *et seq.*

4.3.39 TCA 37-1-401 *et seq*. and 37-1-601 *et seq*.

4.3.40 TCA 68-11-1001 *et seq.*

4.3.41 TCA 71-5-1401 *et seq.*

4.4 TERMINATION

In the event of termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Agreement. For terminations pursuant to Sections 4.4.1, 4.4.2, 4.4.3, 4.4.4, or 4.4.6, TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the CONTRACTOR's MCO.

4.4.1 Termination Under Mutual Agreement

Under mutual agreement, TENNCARE and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of TENNCARE and the CONTRACTOR. Both parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Agreement is terminated.

4.4.2 Termination by TENNCARE for Cause

4.4.2.1 The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

4.4.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

4.4.2.1.2 The CONTRACTOR only renders partial performance of any term or provision of the Agreement; or

4.4.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

4.4.2.2 For purposes of Section 4.4.2, items 4.4.2.1.1 through 4.4.2.1.3 shall hereinafter be referred to as "Breach."

4.4.2.3 In the event of a Breach by the CONTRACTOR, TENNCARE shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this Agreement or available in law or equity:

4.4.2.3.1 Recover actual damages, including incidental and consequential damages, and any other remedy available at law or equity;

4.4.2.3.2 Require that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;

4.4.2.3.3 Recover any and/or all liquidated damages provided in Section 4.20.2; and

4.4.2.3.4 Declare a default and terminate this Agreement.

4.4.2.4 In the event of a conflict between any other Agreement provisions and Section 4.4.2.3, Section 4.4.2.3 shall control.

4.4.2.5 In the event of Breach by the CONTRACTOR, TENNCARE may provide the CONTRACTOR written notice of the Breach and twenty (20) calendar days to cure

the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then TENNCARE shall have available any and all remedies described herein and available at law.

4.4.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

4.4.3 **Termination for Unavailability of Funds**

In the event that federal and/or state funds to finance this Agreement become unavailable, TENNCARE may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by TENNCARE.

4.4.4 **Termination Due to Change in Ownership**

4.4.4.1 In the event that an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, TENNCARE may terminate this Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Agreement provisions regarding mutual termination in Section 4.4.1.

4.4.4.2 In the event that the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) of an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR, TENNCARE may terminate this Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Agreement provisions regarding mutual termination in Section 4.4.1.

4.4.4.3 If an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, or the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in an entity that contracts with TENNCARE to provide covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR, the CONTRACTOR shall notify TENNCARE and shall provide TENNCARE with regular updates regarding the proposed acquisition.

4.4.5 **Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy**

4.4.5.1 If TENNCARE reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services as described herein in the manner required by TENNCARE, TENNCARE may terminate this

Agreement in whole or in part, immediately or in stages. Said termination shall not be deemed a Breach by either party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described herein in the manner required by TENNCARE if the CONTRACTOR can not demonstrate to TENNCARE's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section 2.21.5 of this Agreement.

4.4.5.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor or provider or the insolvency of said subcontractor or provider, the CONTRACTOR shall immediately advise TENNCARE.

4.4.6 **Termination by TENNCARE for Convenience**

TENNCARE may terminate this Agreement for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a Breach of the Agreement by TENNCARE, and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

4.4.7 **Termination by CONTRACTOR**

4.4.7.1 Beginning in calendar year 2008, the CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination on or by July 1 of each calendar year after receipt of notice of the capitation payment rates to become effective in July. Said notice shall terminate the Agreement on the following December 31st.

4.4.7.2 The CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination when risk adjustment factors are updated in accordance with Section 3.4.3.5 due to a significant change in program participation. In this instance, the CONTRACTOR shall provide TENNCARE with written notice of termination within fourteen (14) calendar days of notice of the updated risk adjustment factors and capitation payment rates. Said notice shall terminate the Agreement six (6) months after the date of notice of risk adjustment factors and capitation payment rates plus fourteen (14) calendar days.

4.4.8 **Termination Procedures**

4.4.8.1 The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

4.4.8.2 Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

4.4.8.2.1 Stop work under the Agreement, but not before the termination date;

4.4.8.2.2 At the point of termination, assign to TENNCARE in the manner and extent directed by TENNCARE all the rights, title and interest of the CONTRACTOR for the performance of the subcontracts to be determined at need in which case TENNCARE shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;

4.4.8.2.3 Complete the performance of such part of the Agreement that shall have not been terminated under the notice of termination;

4.4.8.2.4 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement which is in possession of the CONTRACTOR and in which TENNCARE has or may acquire an interest;

4.4.8.2.5 In the event the Agreement is terminated by TENNCARE, continue to serve or arrange for provision of services to the enrollees in the CONTRACTOR's MCO for up to forty-five (45) calendar days from the Agreement termination date or until the members can be transferred to another MCO, whichever is longer. During this transition period, TENNCARE shall continue to make payment as specified in Section 3;

4.4.8.2.6 Promptly make available to TENNCARE, or another MCO acting on behalf of TENNCARE, any and all records, whether medical, behavioral, related to long-term care services or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided at no expense to TENNCARE;

4.4.8.2.7 Promptly supply all information necessary to TENNCARE or another MCO acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;

4.4.8.2.8 Submit a termination plan to TENNCARE for review, which is subject to TENNCARE written approval. This plan shall, at a minimum, contain the provisions in Sections 4.4.8.2.9 through 4.4.8.2.14 below. The CONTRACTOR shall agree to make revisions to the plan as necessary in order to obtain approval by TENNCARE. Failure to submit a termination plan and obtain written approval of the termination plan by TENNCARE shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly capitation payment;

4.4.8.2.9 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims;

4.4.8.2.10 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the appeal process as described in Section 2.19;

4.4.8.2.11 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

4.4.8.2.12 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Agreement to coverage under any new arrangement developed by TENNCARE;

4.4.8.2.13 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Agreement until the State provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled; and

4.4.8.2.14 Upon expiration or termination of this Agreement, submit reports to TENNCARE every thirty (30) calendar days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to TENNCARE describing how the CONTRACTOR has completed its continuing obligations. TENNCARE shall within twenty (20) calendar days of receipt of this report advise in writing whether TENNCARE agrees that the CONTRACTOR has fulfilled its continuing obligations. If TENNCARE finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then TENNCARE shall require the CONTRACTOR to submit a revised final report. TENNCARE shall in writing notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of TENNCARE that the CONTRACTOR has fulfilled its continuing obligations.

30. Section 4.7.2 shall be deleted in its entirety.

31. Section 4.12 shall be amended by replacing "must' with "shall" to read as follows:

4.12 CONTRACTOR APPEAL RIGHTS

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 *et seq*. for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action shall be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Agreement pending the final resolution of the contested action.

32. Section 4.15 shall be amended by correcting a CFR reference and replacing "must" with "shall to read as follows:

4.15 DATA THAT MUST BE CERTIFIED

4.15.1 In accordance with 42 CFR 438.604 and 438.606, when State payments to the CONTRACTOR are based on data submitted by the CONTRACTOR, the CONTRACTOR shall certify the data. The data that shall be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents including the medical loss ratio (MLR) report. The data shall be certified by one of the following: the CONTRACTOR's Chief Executive Officer, the CONTRACTOR's Chief Financial

Officer, or an individual who has delegated authority to sign for, and who reports directly to the CONTRACTOR's Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on best knowledge, information, and belief, as follows:

4.15.1.1 To the accuracy, completeness and truthfulness of the data; and

4.15.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.

4.15.2 The CONTRACTOR shall submit the certification concurrently with the certified data.

33. Sections 4.20 shall be deleted in its entirety and replaced with the following:

4.20 FAILURE TO MEET AGREEMENT REQUIREMENTS

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of CONTRACTOR's failure to meet the requirements provided in this Agreement and all documents incorporated herein, TENNCARE will be harmed. The actual damages which TENNCARE will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the CONTRACTOR shall be subject to damages and/or sanctions as described below. It is further agreed that the CONTRACTOR shall pay TENNCARE liquidated damages as directed by TENNCARE; provided however, that if it is finally determined that the CONTRACTOR would have been able to meet the Agreement requirements listed below but for TENNCARE's failure to perform as provided in this Agreement, the CONTRACTOR shall not be liable for damages resulting directly therefrom.

4.20.1 **Intermediate Sanctions**

4.20.1.1 TENNCARE may impose any or all of the sanctions as described in this Section upon TENNCARE's reasonable determination that the CONTRACTOR failed to comply with any corrective action plan (CAP) as described under Section 2.25.9 or Section 2.23.13 of this Agreement, or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:

4.20.1.1.1 Fails substantially to provide medically necessary covered services;

4.20.1.1.2 Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TENNCARE;

4.20.1.1.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services;

4.20.1.1.4 Misrepresents or falsifies information that it furnishes to CMS or to the State;

4.20.1.1.5 Misrepresents or falsifies information that it furnishes to a member, potential member, or provider;

4.20.1.1.6 Fails to comply with the requirements for physician incentive plans, as required by 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR 422.208 and 422.210;

4.20.1.1.7 Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and

4.20.1.1.8 Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

4.20.1.2 TENNCARE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include:

4.20.1.2.1 Liquidated damages as described in Section 4.20.2;

4.20.1.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

4.20.1.2.3 Disenrollment of members;

4.20.1.2.4 Limitation of the CONTRACTOR's service area;

4.20.1.2.5 Civil monetary penalties as described in 42 CFR 438.704;

4.20.1.2.6 Appointment of temporary management for an MCO as provided in 42 CFR 438.706;

4.20.1.2.7 Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;

4.20.1.2.8 Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or

4.20.1.2.9 Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance.

4.20.2 **Liquidated Damages**

4.20.2.1 <u>Reports and Deliverables</u>

4.20.2.1.1 For each day that a report or deliverable is late, incorrect, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one hundred dollars ($100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.

4.20.2.1.2 Liquidated damages for incorrect reports or deficient deliverables shall begin on the first day after the report/deliverable was due.

4.20.2.1.3 For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due as specified elsewhere in this Agreement or by TENNCARE.

4.20.2.2 Program Issues

4.20.2.2.1 Liquidated damages for failure to perform specific responsibilities or responsibilities as described in this Agreement are shown in the chart below. Damages are grouped into three categories: **Level A**, **Level B**, and **Level C** program issues.

4.20.2.2.2 Failure to perform specific responsibilities or requirements categorized as **Level A** are those which pose a significant threat to patient care or to the continued viability of the TENNCARE program.

4.20.2.2.3 Failure to perform specific responsibilities or requirements categorized as **Level B** are those with pose threats to the integrity of the TENNCARE program, but which do not necessarily imperil patient care.

4.20.2.2.4 Failure to perform specific responsibilities or requirements categorized as **Level C** are those which represent threats to the smooth and efficient operation of the TENNCARE program but which do not imperil patient care or the integrity of the TENNCARE program.

4.20.2.2.5 TENNCARE may also assess liquidated damages for failure to meet performance standards as provided in Section 2.24.3, Attachment VII, and Attachment XI of this Agreement.

4.20.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five hundred dollars ($500) per occurrence with any notice of deficiency.

4.20.2.2.7 *Liquidated Damages Chart*

LEVEL	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in Section 2.22 of this Agreement		$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2.22 of this Agreement
A.2	Failure to comply with licensure and background check requirements in Section 2.29.2 and Attachment XI of this Agreement		$5,000 per calendar day that staff/provider/ /driver/agent/subcontractor is not licensed or qualified as required by applicable state or local law plus the amount paid to the staff/provider/driver/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater

LEVEL	PROGRAM ISSUES		DAMAGE
A.4	Failure to comply with obligations and time frames in the delivery of TENNderCare screens and related services		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater
A.6(a)	Failure to provide a service or make payments for a service within five (5) calendar days of a directive from TENNCARE (pursuant to an appeal) to do so, or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$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.6(b)	Failure to provide proof of compliance to TENNCARE within five (5) calendar days of a directive from TENNCARE or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$500 per day beginning on the next calendar day after default by the CONTRACTOR
A.7	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2.7.8 of this Agreement		$500 per occurrence or the actual amount of the federal penalty created by the CONTRACTOR's failure to comply, whichever is greater
A.8	Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 2.7.5 of this Agreement		$500 per day, per occurrence, for each calendar day that care is not provided in accordance with the terms of this Agreement

LEVEL	PROGRAM ISSUES		DAMAGE
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 beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE
A.10.(a) **A.10.(b)**	Failure to comply with the notice requirements of this Agreement, TennCare rules and regulations or any subsequent amendments thereto, and all court orders and consent decrees governing appeal procedures, as they become effective Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member		$500 per occurrence in addition to $500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE $1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1,000 for the second day, $1,500 for the third day, etc.) for each day the notice is late and/or remains defective
A.11	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days		$500 per calendar day
A.12	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective		$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE

LEVEL	PROGRAM ISSUES		DAMAGE
A.13	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective		First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TENNCARE) Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" ($500 per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; $1,000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)
A.14	Failure to (1) provide an approved service timely, i.e., in accordance with timelines specified in this Agreement, or when not specified therein, with reasonable promptness; or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service		The cost of services not provided plus $500 per day, per occurrence, for each day (1) that approved care is not provided timely; or (2) notice of delay is not provided and/or the CONTRACTOR fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service

LEVEL	PROGRAM ISSUES		DAMAGE
A.15	Failure to comply with the timeframes for developing and approving a plan of care for transitioning CHOICES members in Group 2, initiating nursing facility services for transitioning CHOICES members in Group 1, or initiating long-term care services for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6)		$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS) $10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS) $15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS) $20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS) $25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS)
A.16	Failure to meet the performance standards established by TENNCARE regarding missed visits for personal care, attendant care, homemaker, or home-delivered meals for CHOICES members (referred to herein as "specified HCBS")		$5,000 per month that 11-15% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $10,000 per month that 16-20% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $15,000 per month that 21-25% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $20,000 per month that 26-30% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS $25,000 per month that 31% or more of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS
B.1	Failure to provide referral provider listings to PCPs as required by Section 2.14.3.5 of this Agreement		$500 per calendar day

LEVEL	PROGRAM ISSUES		DAMAGE
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE		$500 per calendar day for each day the corrective action is not completed or complied with as required
B.3	Failure to submit Audited HEDIS and CAHPS results annually by June 15 as described in Sections 2.15.6 and 2.15.7		$250 per day for every calendar day reports are late
B.4	Failure to submit NCQA Accreditation Report as described in Section 2.15.6		$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported
B.5	Failure to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements described in Section 4.19, 4.23, 4.24, or 2.12.9.4.8		110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals
B.6	Failure to disclose Lobbying Activities and/or quarterly conflict of interest disclosure as required by Section 4.24, 4.19, or 2.12.9.4.8		$1000 per day that disclosure is late
B.7	Failure to obtain approval of member materials as required by Section 2.17 of this Agreement		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided member material that has not been approved by TENNCARE
B.8	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, Quarterly Member Newsletters, and CHOICES member education materials as required in Section 2.17		$5000 for each occurrence
B.9	If the CONTRACTOR knew or should have known that a member has not received long-term care services for thirty (30) days or more, failure to report on that member in accordance with Section 2.30.10.5 (see also Section 2.6.1.5.7)		For each member, an amount equal to the CHOICES capitation rate prorated for the period of time in which the member did not receive long-term care services
B.10	Failure to achieve and/or maintain financial requirements in accordance with TCA		$500 per calendar day for each day that financial requirements have not been met
B.11	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.30.15.3		$500 per calendar day

LEVEL	PROGRAM ISSUES		DAMAGE
B.12	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.30.15.3		$500 per calendar day
B.13	Failure to submit audited financial statements as described in Section 2.30.15.3		$500 per calendar day
B.14	Failure to comply with fraud and abuse provisions as described in Section 2.20 of this Agreement		$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions
B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.9.60 of this Agreement		$5000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B
B.16	Failure to maintain a complaint and appeal system as required in Section 2.19 of this Agreement		$500 per calendar day
B.17	Failure to comply with the timeframe for resolving complaints (see Section 2.19.2)		$1,000 per month that the CONTRACTOR's performance is 85-89% $2,000 per month that the CONTRACTOR's performance is 80-84% $3,000 per month that the CONTRACTOR's performance is 75-79% $4,000 per month that the CONTRACTOR's performance is 70-74% $5,000 per month that the CONTRACTOR's performance is 69% or less
B.18	Failure to maintain required insurance as required in Section 2.21.8 of this Agreement		$500 per calendar day
B.19	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.6.3.2 of this Agreement		$1,000 per occurrence per case

LEVEL	PROGRAM ISSUES		DAMAGE
B.20	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement		$500 per occurrence
B.21	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.7.2.9 of this Agreement		$500 per month per Enrollee
B.22	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.7.2.9 of this Agreement		$500 per occurrence per case
B.23	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.15 or A.16		$1,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% $2,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% $3,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% $4,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% $5,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less
B.24	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required in Section 2.11.8 of this Agreement		$5000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable And/Or $1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed as described in Section 2.11.8 of this Agreement

LEVEL	PROGRAM ISSUES		DAMAGE
B.25	Failure to maintain provider agreements in accordance with Section 2.12 and Attachment XI of this Agreement		$5000 per provider agreement found to be non-compliant with the requirements outlined in this Agreement
B.26	Failure to comply with the requirements regarding an agreement to audit accounts (Section 2.21.10)		$1,500 for each day after December 1 of each year that the fully executed agreement for audit accounts is not submitted or for each day after December 1 of each year that the fully executed agreement does not include the required language
C.1	Failure to comply in any way with staffing requirements as described in Section 2.29.1 of this Agreement		$250 per calendar day for each day that staffing requirements are not met
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's MCO		$250 per day
C.3	Failure to comply in any way with encounter data submission requirements as described in Section 2.23 of this Agreement (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE)		$25,000 per occurrence
C.4	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE		An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE
C.5	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 2.4.9.5		$1000.00 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of $5,000 per occurrence
C.6	Failure to comply with the requirements regarding documentation for CHOICES members (see Section 2.9.6)		$500 per plan of care for members in Group 2 or 3 that does not include all of the required elements $500 per member file that does not include all of the required elements $500 per face-to-face visit where the care coordinator fails to document the specified observations

LEVEL	PROGRAM ISSUES		DAMAGE
C.7	Failure to submit a Provider Enrollment File that meets TENNCARE's specifications (see Section 2.30.7.1)		$250 per day after the due date that the Provider Enrollment File fails to meet TENNCARE's specifications

4.20.2.3 Payment of Liquidated Damages

4.20.2.3.1 It is further agreed by TENNCARE and the CONTRACTOR that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days after CONTRACTOR receipt of the notice of damages. If payment is not made by the due date, said liquidated damages may be withheld from future payments by TENNCARE without further notice, as provided in Section 3.14.5 of this Agreement. It is agreed by TENNCARE and the CONTRACTOR that the collection of liquidated damages by TENNCARE shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by TENNCARE will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the liquidated damages described in this Section. With respect to **Level B** and **Level C** program issues (failure to perform responsibilities or requirements), the due dates mentioned above may be delayed if the CONTRACTOR can show good cause as to why a delay should be granted. TENNCARE has sole discretion in determining whether good cause exists for delaying the due dates.

4.20.2.3.2 Liquidated damages as described in Section 4.20.2 shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

4.20.2.3.3 All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the CONTRACTOR out of administrative costs and profits.

4.20.2.4 Application of Liquidated Damages for CHOICES

In applying liquidated damages related to care coordination timeframes (see A.15 and B.23), HCBS missed visits (see A.16), and the CHOICES Utilization Report (see B.9) TENNCARE may take into consideration whether, as determined by TENNCARE, the CONTRACTOR promptly remedied a deficiency and/or a deficiency was due to circumstances beyond the CONTRACTOR's control. Such consideration shall be based on information provided by the CONTRACTOR in the applicable report (see Section 2.30) and/or additional information submitted by the CONTRACTOR as requested by TENNCARE.

4.20.2.5 Waiver of Liquidated Damages

TENNCARE may waive the application of liquidated damages and/or withholds upon the CONTRACTOR if the CONTRACTOR is placed in rehabilitation or under administrative supervision if TENNCARE determines that such waiver is in the best interests of the TennCare program and its enrollees.

4.20.3 **Claims Processing Failure**

If it is determined that there is a claims processing deficiency related to the CONTRACTOR's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section 2.22, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of liquidated damages and/or intermediate sanctions specified in Sections 4.20.1 and 4.20.2 and the retention of withholds as specified in Section 3.9. If the CONTRACTOR is unable to successfully implement corrective action and demonstrate adherence with timely claims processing requirements within the time approved by TENNCARE, the State may terminate this Agreement in accordance with Section 4.4 of this Agreement.

4.20.4 **Failure to Manage Medical Costs**

If TENNCARE determines the CONTRACTOR is unable to successfully manage costs for covered services, TENNCARE may terminate this Agreement with ninety (90) calendar days advance notice in accordance with Section 4.4 of this Agreement.

4.20.5 **Sanctions by CMS**

Payments provided for under this Agreement will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

4.20.6 **Temporary Management**

TENNCARE may impose temporary management if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

34. Section 4.24.1 shall be amended by deleting the parenthetical and shall read as follows:

4.24.1 The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352.

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

4.30 VOLUNTARY BUYOUT PROGRAM

4.30.1 The CONTRACTOR acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.

4.30.2 The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.

4.30.3 The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the CONTRACTOR understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse CONTRACTOR personnel. Inasmuch, it shall be the responsibility of the State to review CONTRACTOR personnel to identify any such issues.

4.30.4 With reference to either Section 4.30.2 or 4.30.3 above, the CONTRACTOR may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Agreement, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

36. Section 4.34 shall be amended to replace "Contractor" with "CONTRACTOR" and "contract" with "Agreement" and shall read as follows:

4.34 PROHIBITION OF ILLEGAL IMMIGRANTS

4.34.1 The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

4.34.2 The CONTRACTOR hereby attests, certifies, warrants, and assures that the CONTRACTOR shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Agreement. The CONTRACTOR shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment X,

hereto, semi-annually during the period of this Agreement. Such attestations shall be maintained by the contractor and made available to state officials upon request.

4.34.3 Prior to the use of any subcontractor in the performance of this Agreement, and semi-annually thereafter, during the period of this Agreement, the CONTRACTOR shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Agreement. Attestations obtained from such subcontractors shall be maintained by the CONTRACTOR and made available to state officials upon request.

4.34.4 The CONTRACTOR shall maintain records for all personnel used in the performance of this Agreement. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

4.34.5 The CONTRACTOR understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Agreement.

4.34.6 For purposes of this Agreement, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Agreement.

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

4.37 FEDERAL ECONOMIC STIMULUS FUNDING

This Agreement requires the CONTRACTOR to provide products and/or services that are funded in whole or in part under the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (Recovery Act). The CONTRACTOR is responsible for ensuring that all applicable requirements of the Recovery Act are met and that the CONTRACTOR provides information to the State as required by, but not limited to, the following:

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

4.37.1.1 Section 1606 – Wage Rate Requirements.

4.37.1.2 Section 1512 – Reporting and Registration Requirements.

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

4.37.1.4 Section 1553 – Whistleblower Protections.

4.37.1.5 Section 1605 – Buy American Requirements for Construction Material.

4.37.2 Executive Office of the President, Office of Management and Budget (OMB) Guidelines as posted at http://www.whitehouse.gov/omb/recovery_default/, as well as OMB Circulars, including but not limited to A-102 and A-133 as posted at http://www.whitehouse.gov/omb/financial_offm_circulars/.

4.37.3 Federal Grant Award Documents.

4.37.4 Office of Tennessee Recovery Act Management Directives.

38. Attachment I shall be deleted in its entirety and replaced with the following:

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

SERVICE	**Mental Health Case Management**

DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

1) All mental health case managers shall have, at a minimum, a bachelor's degree;
2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
4) Eighty percent (80%) of all mental health case management services should take place outside the case manager's office;
5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the ACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) No arbitrary time limit on receiving services;
8) Individualized treatment, support and rehabilitation services;
9) Twenty-four (24) hour a day availability of services; and
10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the “imminent” risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation

DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members and are Certified Peer Support Specialists. These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

39. Attachment II shall be deleted in its entirety and replaced with the following:

ATTACHMENT II
COST SHARING SCHEDULE

Non-Pharmacy Copayment Schedule Prior to January 1, 2010
(unless otherwise directed by TENNCARE)

Poverty Level	Copayment Amounts
0% - 99%	$0.00
100% - 199%	$25.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists (including Psychiatrists) $200.00, Inpatient Hospital Admission

Non-Pharmacy Copayment Schedule Effective January 1, 2010
(unless otherwise directed by TENNCARE)

Poverty Level	Copayment Amounts
0% - 99%	$0.00

100% - 199%	$10.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $5.00, Physician Specialists (including Psychiatrists) $5.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $15.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $20.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)

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

40. Attachment III shall be deleted in its entirety and replaced with the following:

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.

- Long-Term Care Services:

  Transport time for adult day care will be the usual and customary, not to exceed 30 miles.

- 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.

41. Attachment V shall be deleted in its entirety and replaced with the following:

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Travel distance does not exceed 75 miles for at least 75% of **ADULT** members and does not exceed 150 miles for at least 90% of **ADULT** members ---------- Travel distance does not exceed 60 miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours

Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)*	Travel distance does not exceed 75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support (TDMHDD Rule Chapter 1940-5-29)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Travel distance does not exceed 60 miles for at least 75% of **ADULT** members and does not exceed 90 miles for at least 90% of **ADULT** members	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

*24 Hour Residential Treatment Substance Abuse Services may be provided by facilities licensed by the Tennessee Department of Health as Halfway House Treatment Facilities (DOH Rule Chapter 1200-8-17), Residential Detoxification Treatment Facilities (DOH Rule Chapter 1200-8-22) or Residential Rehabilitation

Treatment Facilities (DOH Rule Chapter 1200-8-23). (Effective 1/1/2008, the Tennessee Department of Mental Health and Developmental Disabilities will license these facilities.)

When the above standards are not met, an acceptable Corrective Action Plan will be requested which details the CONTRACTOR's intended course of action to resolve any deficiency (ies) identified. The Bureau of TennCare will evaluate Corrective Action Plans and, at its sole discretion, determine network adequacy considering any alternate measures and documentation of unique market conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult – 41

42. Attachment VII shall be deleted in its entirety and replaced with the following:

ATTACHMENT VII
PERFORMANCE STANDARDS

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
1	Timely Claims Processing	Report from TDCI	90% of clean electronic claims for nursing facility services and HCBS excluding PERS, assistive technology, minor home modifications, and pest control are processed and paid within fourteen (14) calendar days of receipt 99.5% of clean electronic claims for nursing facility and HCBS other than PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt 90% of all other claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of all other claims are processed within sixty (60) calendar days.	Percentage of clean electronic claims paid within 14 calendar days of receipt of claim, for each month Percentage of clean electronic claims processed within 21 calendar days of receipt of claim, determined for month Percentage of claims paid within 30 calendar days of receipt of claim, for each month Percentage of claims processed within 60 calendar days of receipt of claim, for each month	Monthly	$10,000 for each month determined not to be in compliance
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately for each month and by provider type (NF, HCBS, and other)	Monthly	$5,000 for each full percentage point accuracy is below 97% for each month for each provider type (NF, HCBS, and other)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness –Provider Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
5	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month
6	Telephone Call Abandonment Rate (unanswered calls) – Provider Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month
7(a)	Left blank intentionally					
7(b)	Left blank intentionally					

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	100% of providers on the Provider Enrollment File have a signed provider agreement with the CONTRACTOR		Upon TENNCARE request	$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
9	Specialist Provider Network	Provider Enrollment File	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology 2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service 3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s) 4. Center of Excellence for Behavioral Health: Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
10	HCBS Provider Network	Provider Enrollment File	At least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county in the Grand Region	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Quarterly	Beginning after the first calendar quarter following implementation of CHOICES in the Grand Region covered by this Agreement, $25,000 if ANY of the listed standards are not met, either individually or in combination on a quarterly basis The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of HCBS provider serving the county and the CONTRACTOR has used good faith efforts to develop HCBS providers to serve the county. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
11	Provider Participation Accuracy	Provider Enrollment File	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Quarterly	$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers in the sample are participating
12	Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of listed providers is incorrect for each data element	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for each element as determined by TENNCARE	Quarterly	$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for each data element $25,000 per quarter if data for more than 30% of providers is incorrect for each data element The $25,000 liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
13	Distance from provider to member	Provider Enrollment File	In accordance with this Agreement, including Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE. For the first six months after CHOICES implementation, TENNCARE will waive the liquidated damage related to distance to adult day care if the CONTRACTOR demonstrates that it is providing NEMT to adult day care in accordance with Section 2.11.1.8. Thereafter, TENNCARE may waive the liquidated damage regarding distance to adult day care if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of adult day care providers and the CONTRACTOR has used good faith efforts to develop adult day care providers.

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
14	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment V
15	Percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment)	Claims and encounter data	The percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment) will not be less than 76%	The number of SPMI/SED members receiving a behavioral health service (excluding a CRG/TPG assessment) during the fiscal year divided by the MCO's number of SPMI/SED members during the fiscal year is not less than the benchmark	Annually	$25,000 for each year determined to not be in compliance
16	Non-IMD Inpatient Use	Behavioral Health Crisis Service Response Reports and utilization data	10% decrease of total inpatient days at freestanding psychiatric hospitals subject to IMD exclusion compared to the base year's utilization	Total inpatient psychiatric hospital days at IMD exclusion facilities for members reduced by 10% after base line year	Annually	$10,000 for each year determined to not be in compliance
17	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Quarterly	$5,000 for each full percentage point TENNderCare screening ratio is below 80% for the most recent rolling twelve month period
18	Increase in utilization of supported employment	Supported Employment Reports	15% of all adults (21 – 64 years of age) designated as SPMI actively receiving supported employment services will be gainfully employed in either part time or full time capacity for a continuous 90 day period within one (1) year of receiving supported employment services	Total number of SPMI adults receiving supported employment services as defined in Attachment I employed for a continuous 90-day period within one (1) year of receiving supported employment services divided by the total number of SPMI adults	Annually	$25,000 for each year determined to not be in compliance
19	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60%

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
20	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health case management service	Mental Health Case Management Report	90% of discharged members *receive* a mental health case management service as medically necessary within seven (7) calendar days of discharge, excluding situations involving member reschedules, no shows, and refusals	(1) Number of members discharged by length of time between discharge and first subsequent mental health case management service as medically necessary reported by CMHA and type of service received; determined for each month (2) Average length of time between hospital discharge and first subsequent medically necessary MHCM visit reported by CMHA and type of service received excluding member reschedules, no shows, and refusals; determined for each month	Quarterly	$3,000 for each quarter determined to not be in compliance
21	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly	$1,500 for each quarter determined to not be in compliance
22	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly	$1,500 for each quarter determined to not be in compliance
23	Members are satisfied with the services they receive from behavioral health providers	Annual consumer satisfaction survey administered by TDMHDD	85% of respondents rate their experience to be fair or better	Distribution of members by satisfaction score	Annually	$10,000 for each response below 85%

43. Attachment VIII shall be deleted in its entirety and replaced with the following:

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the TennCare Bureau unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Policies and procedures for patient liability that ensure compliance with Section 2.6.7.2

6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3

7. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.4

8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6

9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7

10. Disease management program policies and procedures that ensure compliance with Section 2.8

11. Service coordination policies and procedures that ensure compliance with Section 2.9.1

12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3

14. Transition of care polices and procedures that ensure compliance with Section 2.9.4

15. MCO case management policies and procedures that ensure compliance with Section 2.9.5

16. Care coordination policies and procedures that ensure compliance with Section 2.9.6

17. Policies and procedures for consumer direction of HCBS that ensure compliance with Section 2.9.7

18. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section 2.9.8

19. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.8.2 to ensure compliance with Section 2.9.8

20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.9

21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.10

22. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.11

23. Identification of members serving on the claims coordination committee in accordance with Section 2.9.11.5.3

24. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.12

25. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.14

26. Polices and procedures regarding non-covered services that ensure compliance with Section 2.10

27. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

28. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

29. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

30. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8

31. Policies and procedures that ensure compliance with notice requirements in Section 2.11.9

32. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.9.2

33. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

34. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.9.49)

35. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.8)

36. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.8)

37. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.9.1

38. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9

39. Information on PCP profiling as requested by TENNCARE (see Section 2.14.9)

40. QM/QI policies and procedures to ensure compliance with Section 2.15

41. Copy of signed contract with NCQA approved vendor to perform CAHPS as required by Section 2.15.5

42. Copy of signed contract with NCQA approved vendor to perform HEDIS audit as required by Section 2.15.5

43. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.5.1)

44. HEDIS BAT as required by Section 2.15.6

45. Copy of signed NCQA survey contract as required by Section 2.15.5.1

46. Notice of date for ISS submission and NCQA on-site review as required by Section 2.15.5.1

47. Notice of final payment to NCQA as required by Section 2.15.5.1

48. Notice of submission of ISS to NCQA as required by Section 2.15.5.1

49. Copy of completed NCQA survey and final report as required by Section 2.15.5.1

50. Notice of any revision to NCQA accreditation status

51. Policies and procedures regarding critical incident management and reporting to ensure compliance with Section 2.15.8

52. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletters, identification card, and provider directory along with any required supporting materials

53. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

54. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

55. Provider service and phone line policies and procedures that ensure compliance with Section 2.18.4

56. Description of 24/7 ED Assistance Line (see Section 2.18.4.7)

57. Provider handbook that is in compliance with requirements in Section 2.18.5

58. Provider education and training plan and materials that ensure compliance with Section 2.18.6

59. Provider relations policies and procedures in compliance with Section 2.18.7

60. Protocols regarding one-on-one assistance to long-term care providers that ensure compliance with Section 2.18.7.2

61. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.3)

62. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

63. FEA education and training plan and materials that ensure compliance with Section 2.18.9

64. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.10

65. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

66. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

67. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

68. Fraud and abuse compliance plan (see Section 2.20.3)

69. TPL policies and procedures that ensure compliance with Section 2.21.4

70. Accounting policies and procedures that ensure compliance with Section 2.21.7

71. Proof of insurance coverage (see Section 2.21.8)

72. Executed agreement for audit accounts that contains the required language (see Section 2.21.11)

73. Claims management policies and procedures that ensure compliance with Section 2.22

74. Internal claims dispute procedure (see Section 2.22.5)

75. EOB policies and procedures to ensure compliance with Section 2.22.8

76. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

77. Proposed approach for remote access in accordance with Section 2.23.6.10

78. Information security plan as required by Section 2.23.6.11

79. Notification of Systems problems in accordance with Section 2.23.7

80. Systems Help Desk services in accordance with Section 2.23.8

81. Notification of changes to Systems in accordance with Section 2.23.9

82. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

83. Notification of changes to membership of CHOICES Advisory Group and current membership lists in accordance with Section 2.24.3

84. An abuse and neglect plan in accordance with Section 2.24.4

85. Medical record keeping policies and procedures that ensure compliance with Section 2.24.6

86. Subcontracts (see Section 2.26)

87. HIPAA policies and procedures that ensure compliance with Section 2.27

88. Accounting of disclosures in accordance with Section 2.27.2.10

89. Notification of use or disclosure in accordance with Section 2.27.2.13.3.3

90. Notification of any unauthorized acquisition of enrollee PHI in accordance with Section 2.27.2.13.3

91. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27.2.27

92. Notification of any security incident in accordance with Section 2.27.3

93. Non-discrimination policies and procedures as required by Section 2.28

94. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

95. Changes to key staff as required by Section 2.29.1.2

96. Staffing plan as required by Section 2.29.1.8

97. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.9

98. Background check policies and procedures that ensure compliance with Section 2.29.2.1

99. List of officers and members of Board of Directors (see Section 2.29.3)

100. Changes to officers and members of Board of Directors (see Section 2.29.3)

101. Eligibility and Enrollment Data (see Section 2.30.2.1)

102. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)

103. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)

104. Information on members (see Section 2.30.2.4)

105. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)

106. Mental Health Case Management Report (see Section 2.30.4.2)

107. Supported Employment Report (see Section 2.30.4.3)

108. Behavioral Health Crisis Response Report (see Section 2.30.4.4)

109. Member CRG/TPG Assessment Report (see Section 2.30.4.5)

110. Rejected CRG/TPG Assessment Report (see Section 2.30.4.6)

111. CRG/TPG Assessments Audit Report (see Section 2.30.4.7)

112. Methodology for conducting CRG/TPG assessment audits (see Section 2.30.4.8)

113. Adverse Occurrences Report (see Section 2.30.4.9)

114. TENNderCare Report (see Section 2.30.4.10)

115. Self-Directed Health Care Tasks Report (see Section 2.30.4.11)

116. Disease Management Update Report (see Section 2.30.5.1)

117. Disease Management Report (see Section 2.30.5.2)

118. Disease Management for CHOICES Update Report (see Section 2.30.5.3)

119. Disease Management for CHOICES Report (see Section 2.30.5.4)
120. Disease Management Program Description (see Section 2.30.5.5)

121. MCO Case Management Program Description (see Section 2.30.6.1.1)

122. MCO Case Management Services Report (see Section 2.30.6.1.2)

123. MCO Case Management Update Report (see Section 2.30.6.1.3)

124. Status of Transitioning CHOICES Member Report (see Section 2.30.6.2)

125. New Member Assessment and Care Planning and Initiation of Services Report (see Section 2.30.6.3)

126. CHOICES Intake, Enrollment, and Service Initiation Report (see Section 2.30.6.4)

127. Ongoing Assessment and Care Planning and Service Initiation Report (see Section 2.30.6.5)

128. Post-Enrollment Care Coordination Contact Report (see Section 2.30.6.6)

129. Nursing Facility Diversion Report (see Section 2.30.6.7)

130. Nursing Facility to Community Transition Report (see Section 2.30.6.8)

131. Nursing Facility Utilization Report (see Section 2.30.6.9)

132. Missed Visits Report (see Section 2.30.6.10)

133. Care Coordination Staffing Report (see Section 2.30.6.11)

134. Care Coordination Quality Assurance Plan and Care Coordination Quality Assurance Plan Report (see Section 2.30.6.12)

135. Consumer Direction of HCBS Report (see Section 2.30.6.13)

136. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.14)

137. Pharmacy Services Report (see Section 2.30.6.15)

138. Pharmacy Services Report, On Request (see Section 2.30.6.16)

139. Provider Enrollment File (see Section 2.30.7.1)

140. Provider Compliance with Access Requirements Report (see Section 2.30.7.2)

141. PCP Assignment Report (see Section 2.30.7.3)

142. Report of Essential Hospital Services (see Section 2.30.7.4)

143. Behavioral Health Initial Appointment Timeliness Report (see Section 2.30.7.5)

144. Long-Term Care Provider Network Development Plan (see Section 2.30.7.6)

145. Long-Term Care Provider Capacity Performance Report (see Section 2.30.7.7)

146. Qualified Workforce Strategies Report (see Section 2.30.7.8)

147. FQHC Reports (see Section 2.30.7.9)

148. Institutions for Mental Diseases (IMD) Out-of-State Report (see Section 2.30.7.10)

149. Single Case Agreements Report (see Section 2.30.8)

150. Related Provider Payment Report (see Section 2.30.9)

151. UM program description, work plan, and evaluation (see Section 2.30.10.1)

152. Cost and Utilization Reports (see Section 2.30.10.2)

153. Cost and Utilization Summaries (see Section 2.30.10.3)

154. Identification of high-cost claimants (see Section 2.30.10.4)

155. CHOICES Utilization Report (see Section 2.30.10.5)

156. Prior Authorization Reports (see Section 2.30.10.6)

157. Referral Provider Listing and supporting materials (see Section 2.30.10.7)

158. ED Threshold Report (see Section 2.30.10.8)

159. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.11.1)

160. Report on Performance Improvement Projects (see Section 2.30.11.2)

161. NCQA Accreditation Report (see Section 2.30.11.3)

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

163. Reports of Audited CAHPS Results and Audited HEDIS Results (see Section 2.30.11.5)

164. Health Outcomes Survey data files (see Section 2.30.11.6)

165. Critical Incidents Report (see Section 2.30.11.7)

166. Member Services and Provider Services Phone Line Report (see Section 2.30.12.1.1)

167. 24/7 Nurse Triage Line Report (see Section 2.30.12.1.2)

168. ED Assistance Tracking Report (see Section 2.30.12.1.3)

169. Translation/Interpretation Services Report (see Section 2.30.12.3)

170. Provider Satisfaction Survey Report (see Section 2.30.12.4)

171. Provider Complaints Report (see Section 2.30.12.5)

172. Member Complaints Report (see Section 2.30.13)

173. Fraud and Abuse Activities Report (see Section 2.30.14.1)

174. Policies in compliance with Section 1902(a)(68) of the Social Security Act (see Section 2.30.14.3)

175. Recovery and Cost Avoidance Report (see Section 2.30.15.1.1)

176. Other Insurance Report (see Section 2.30.15.1.2)

177. Patient Liability Report (see Section 2.30.15.2)

178. Medical Loss Ratio (MLR) Report (see Section 2.30.15.3.1)

179. Ownership and Financial Disclosure Report (see Section 2.30.15.3.2)

180. Annual audit plan (see Section 2.30.15.3.3)

181. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.15.4.1)

182. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.15.4.2)

183. Annual Financial Report (to TDCI) (see Section 2.30.15.4.3)

184. Quarterly Financial Report (to TDCI) (see Section 2.30.15.4.4)

185. Audited Financial Statements (to TDCI) (see Section 2.30.15.4.5)

186. Claims Payment Accuracy Report (see Section 2.30.16.1)

187. EOB Report (see Section 2.30.16.2)

188. Claims Activity Report (see Section 2.30.16.3)

189. HCBS Annual Benefit limits Report (see Section 2.30.16.4)

190. Cost Neutrality Report (see Section 2.30.16.5)

191. Expenditure Cap Report (see Section 2.30.16.6)

192. Cost Effective Alternative Services for CHOICES Report (see Section 2.30.16.7)

193. Systems Refresh Plan (see Section 2.30.17.1)

194. Encounter Data Files (see Section 2.30.17.2)

195. Electronic version of claims paid reconciliation (see Section 2.30.17.3)

196. Information and/or data to support encounter data submission (see Section 2.30.17.4)

197. Systems Availability and Performance Report (see Section 2.30.17.5)

198. Business Continuity and Disaster Recovery Plan (see Section 2.30.17.6)

199. Reports on the Activities of the CONTRACTOR’s Behavioral Health Advisory Committee (see Section 2.30.18.1)

200. Report on the Activities of the CONTRACTOR's CHOICES Advisory Group (see Section 2.30.18.2)

201. Subcontracted claims processing report (see Section 2.30.19.1)

202. Security Incident Report (see Section 2.30.20)

203. Summary Listings of Servicing Providers (see Section 2.30.21.1)

204. Supervisory Personnel Report (see Section 2.30.21.2)

205. Alleged Discrimination Report (see Section 2.30.21.3)

206. Non-discrimination policy (see Section 2.30.21.4)

207. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.21.5)

208. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1

209. Disclosure of conflict of interest (see Section 2.30.22.1)

210. Attestation Re: Personnel Used in Contract Performance (see Section 2.30.22.2)

211. Return of funds in accordance with Section 3.14.5

212. Termination plan in accordance with Section 4.4.8.2.8

213. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI

44. Delete Attachment IX, Exhibit A, Quarterly Enrollment/Capitation Payment Reconciliation Reports, and replace with "Intentionally Left Blank."

45. Attachment IX, Exhibit G shall be deleted in its entirety and replaced with the following:

ATTACHMENT IX, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES

Instructions for Completing *Report of Essential Hospital Services*

The chart for the *Report of Essential Hospital Services* required in Section 2.30.7.4 is to be prepared based on the CONTRACTOR's provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.
- Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.

1. In the first column, "Name of Facility" indicate the complete name of the facility.

2. In the second column, "TennCare ID" indicate the TennCare ID assigned to the facility.

3. In the third column, "NPI" indicate the National Provider Identifier issued to the facility.

4. In the fourth column, "City/Town" indicate the city or town in which the designated facility is located.

5. In the fifth column, "County" indicate the name of the county in which this facility is located.

6. In the sixth through the twelfth columns indicate the status of the CONTRACTOR's relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, and Centers of Excellence for Behavioral Health. For example:

   - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an "E" in the column labeled "Neonatal".

   - If the CONTRACTOR does not have an executed provider agreement with this facility for "Neonatal", but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.

   - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled "neonatal" blank.

ATTACHMENT IX, EXHIBIT G
ESSENTIAL HOSPITAL SERVICES REPORT

MCO Name:_____ **Grand Region: _____**

Number of TennCare Members:_____ **as of (date): _____**

Name of Facility	TennCare ID	NPI	City/ Town	County	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Center of Excellence for Behavioral Health	Comments

E = Executed Provider Agreement
L = Letter of Intent
R = On Referral Basis
N = In Contract Negotiations
O = Other Arrangement

If no relationship for a particular service leave cell blank

46. Delete Attachment IX, Exhibit J, Cost and Utilization Reports, and replace with "Intentionally Left Blank."

47. Delete Attachment IX, Exhibit K, Cost and Utilization Summaries, and replace with the following:

ATTACHMENT IX, EXHIBIT K
COST AND UTILIZATION SUMMARIES

The quarterly *Cost and Utilization Summaries* required in Section 2.30.10.3 shall include information for each of the following populations:

- Medicaid
- Uninsured
- Medically Eligible Child
- Non-CHOICES Disabled
- Non-CHOICES Duals
- CHOICES Duals
- CHOICES Non-Duals

Summaries for the following shall be provided:

1) Data elements for *Top 25 Providers (broken down by facilities, practitioners, ancillary providers, transportation providers) by Amount Paid*

    - Rank
    - Provider type
    - Provider Name
    - Street Address (Physical Location)
    - City
    - State
    - Zip Code
    - Amount Paid to Each Provider
    - Amount Paid as a Percentage of Total Provider Payments

2) Data elements for *Top 25 Inpatient Diagnoses by Number of Admissions*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Amount Paid
    - Admits
    - Admits as a Percentage of Total Admits

3) Data elements for *Top 25 Inpatient Diagnoses by Amount Paid*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description

- Admits
- Amount Paid
- Amount Paid as a Percentage of Total Inpatient Dollars

4) Data elements for *Top 25 Outpatient Diagnoses by Number of Visits*

- Rank
- Diagnosis code
- Description
- Amount Paid
- Visits
- Visits as a percentage of Total Outpatient Visits

5) Data elements for *Top 25 Outpatient Diagnoses by Amount Paid*

- Rank
- Diagnosis Code
- Description
- Visits
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Payments

6) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Number of Admissions*

- Rank
- DRG Code
- Description
- Amount Paid
- Number of Admissions
- Admissions as a Percentage of Total Admissions

7) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Amount Paid*

- Rank
- DRG Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

8) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Number of Procedures*

- Rank
- Procedure Code
- Description
- Amount Paid
- Number of Procedures
- Procedures as a Percentage of Total Surgical/Maternity Procedures

9) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Amount Paid*

- Rank
- Procedure Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

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

49. Attachment IX, Exhibit M, shall be deleted and replaced with the following:

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND PROVIDER SERVICES PHONE LINE REPORT

Instructions for Completing the *Member Services and Provider Services Phone Line Report*

The following definitions shall be used:

Abandoned Call: A call in the phone line queue that is terminated by the caller before reaching a live voice.

Average Time to Answer: The average time that callers waited in the phone line queue (when the call was placed during the hours the phone line is open for services) before speaking to a MCO representative. This shall be reported in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

Call Abandonment Rate: The number of calls (where the member/provider called directly into the phone line or selected a member/provider services option and was put in the call queue) that are abandoned by the caller or the system before being answered by a live voice, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

Call Answer Timeliness: The number of calls (where the member called directly into the phone line or selected a member/provider services option and was put in the call queue) that are answered by a live voice within thirty (30) seconds, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND PROVIDER SERVICES PHONE LINE REPORT

MCO Name:_____

Report Submission Date:_____

Reporting Quarter:_____

		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Nurse Triage Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Provider Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			

50. Delete Attachment IX, Exhibit N, Medical Loss Ratio Report, and replace with "Intentionally Left Blank"

51. Attachment X shall be deleted in its entirety and replaced with the following:

ATTACHMENT X

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

_____

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

_____

PRINTED NAME AND TITLE OF SIGNATORY

_____

DATE OF ATTESTATION

52. In Attachment XI, NEMT Requirements, Section A.12.5 is deleted in its entirety and replaced with the following:

A.12.5 The CONTRACTOR shall provide Division of Mental Retardation Services (DMRS) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers. These providers shall only provide covered NEMT services to members receiving HCBS MR waiver services from the provider. The CONTRACTOR shall reimburse these providers for covered NEMT to TennCare covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided though a HCBS MR waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

53. In Attachment XI, NEMT Requirements, Item 13 in Exhibit A is deleted in its entirety and replaced with the following:

13. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, dental services, and institutional services. TennCare covered services includes TENNderCare services. For purposes of NEMT, TennCare covered services does not include alternatives to institutional services (HCBS or 1915(c) waiver services).

54. Effective July 1, 2009, Exhibit C of Attachment XII shall be amended by deleting the words "through June 30, 2009" at the top of the chart. Further, effective upon the CHOICES Implementation Date, Exhibit C, Attachment XII shall be amended by adding the following capitation rate cells: "CHOICES Duals - $4,529.19 PMPM" and "CHOICES Non-Duals - $5,942.45 PMPM".

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained, this Amendment shall become effective September 1, 2009.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: 8/24/09

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY: _____
Eric H. Paul
Chief Executive Officer, TennCare

DATE: 8/21/09

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: 9/1/09

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
Justin P. Wilson
Comptroller

DATE: 9/11/09

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
318.66-051	FA-07-16937-03

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

Contractor Name	Contractor ID # (FEIN or SSN)
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	June 30, 2010	subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010					$ -
					$ -
					$ -
TOTAL:	$ 570,752,364.00	$ 1,003,085,672.00	$ -	$ -	$ 1,573,838,036.00

OCR RELEASED JUL 09 2008 TO Agency

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009		$ 699,483,574.00
2010		
		$ -
TOTAL:	$ 874,354,462.00	$ 699,483,574.00
End Date	June 30, 2010	

State Agency Fiscal Contact & Telephone #

Scott Pierce 507-6415

State Agency Budget Officer Approval

Scott Pierce

Funding Certification (certification required by T.C.A. § 9-4-5106 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)

RECEIVED JUL 1 3 2008 CHAPTER OFFICE OF MANAGEMENT SERVICES

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

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government (eg,ID,GG,GU) [ ] Other

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

OCR JUL 02 2008

CONTRACT SUMMARY SHEET

021406

318.66-051	FA-07-16937-03
Department of Finance and Administration	Bureau of TennCare
UnitedHealthCare Plan of the River Valley, Inc.	C- or X V- 363379945 01

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

August 15, 2006	June 30, 2010	subrecipient	93.778 Dept. of Health and Human Services/Title XIX

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

318.66	4M9	134	11		

2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009	$253,667,718.00	$445,815,856.00			$ 699,483,574.00
2010					$ -
					$ -
					$ -
	$ 570,752,364.00	$ 1,003,085,672.00	$ -	$ -	$ 1,573,838,036.00

Scott Pierce 687-6416

2007	$174,870,988.00	
2008	$ 699,483,574.00	
2009		$ 699,483,574.00
2010		
		$ -
	$ 874,354,462.00	$ 699,483,574.00
	June 30, 2010	

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

X	RFP		Competitive Negotiation			Alternative Competitive Method	
	Non-Competitive Negotiation		Negotiation w/ Government(eg.10,OG,GU)			Other	

AMENDMENT NUMBER 3

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

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC., hereinafter referred to as the CONTRACTOR as specified below.

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

1. The "Medicaid Eligible, Age 21 and older:" designation in the "Benefit Limit" chart of Sections 2.6.1.2 and 2.6.1.4 shall be deleted and replaced with "Medicaid/Standard Eligible, Age 21 and older:".

2. The Non-Emergency Transportation Benefit description in Section 2.6.1.2 shall be deleted in its entirety and substituted with the following:

Non-Emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional

	payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18). The CONTRACTOR is not responsible for providing NEMT to any service that is being provided to the member through a HCBS waiver. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service. If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2.7.5.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.

3. Section 2.6.5 shall be amended by deleting "and CMS" at the end of the paragraph.

4. Sections 2.7.5.4.6.1 through 2.7.5.4.6.5 shall be deleted in their entirety and substituted with the following:

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

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

5. Section 2.8.8 shall be deleted and replaced in its entirety.

2.8.8 **Obesity Disease Management**

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.5). The CONTRACTOR may fulfill this requirement by entering into a provider agreement with Weight Watchers and then referring/authorizing eligible obese and overweight members to participate in a Weight Watchers program. If the CONTRACTOR identifies another weight management program as the cost effective alternative service, the CONTRACTOR shall include a narrative of the program (including target population and description of services) as part of its quarterly disease management report (see Section 2.30.5.1) applicable to the quarter in which the program was implemented.

6. Section 2.9.8.1.3 shall be deleted in its entirety and substituted with the following:

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

7. Section 2.11.3.4 shall be deleted in its entirety.

8. Section 2.11.7.5 shall be deleted and replaced in its entirety.

2.11.7.5 <u>Weight Watchers or Other Weight Management Program</u>

The CONTRACTOR is not required to credential the Weight Watchers or the weight management program(s) referenced in Section 2.8.8 of this Agreement.

9. Section 2.12.7 shall be amended by adding a new Section 2.12.7.32 and renumbering existing subparts accordingly, including any references thereto.

2.12.7.32 As a condition of reimbursement for global procedures codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;

10. Section 2.13 shall be amended by adding a new Section 2.13.2 and renumbering existing subparts accordingly, including any references thereto.

2.13.2 **All Covered Services**

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

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

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

11. Section 2.13.11 shall be deleted and replaced as follows:

2.11.1 **Covered Services Ordered by Medicare Providers for Dual Eligibles**

2.13.11.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR must pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contracted provider:

2.13.11.1.1 The ordered services requires prior authorization; and

2.13.11.1.2 Dually eligible enrollees have been clearly informed of the contracted provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and

2.13.11.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.

2.13.11.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.11.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

12. Section 2.15.3.1 shall be deleted and replaced in its entirety.

2.15.3.1 The CONTRACTOR shall perform three (3) clinical and two (2) non-clinical PIPs.. The three (3) clinical PIPs shall include one (1) in the area of diabetes management, one (1) in the area of maternity management and one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.

13. Section 2.15.4.1 shall be deleted and replaced in its entirety.

2.15.4.1 The CONTRACTOR's QM/QI program shall identify benchmarks and set achievable performance goals for the three (3) clinical PIPs and two (2) non-clinical PIPs

required in Section 2.15.3. The three (3) clinical performance indicators that must show meaningful improvement are diabetes management, maternity management and behavioral health. The CONTRACTOR shall identify a relevant HEDIS measure where there is an opportunity to show improvement. The source of the benchmark should be identified, e.g., NCQA's Quality Compass. The CONTRACTOR must demonstrate improvement against the baseline measure as indicated:

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

14. Section 2.17.1.1 shall be deleted and replaced in its entirety.

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior approval all materials that will be distributed to members (referred to as member materials) as well as proposed health education and outreach activities. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, Section 2.17 and Section 2.7.3, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

15. Section 2.30.4.4 and 5 shall be deleted and replaced in its entirety.

2.30.4.4 The CONTRACTOR shall submit a quarterly Behavioral Health Crisis Response Report that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements listed in Attachment IX, Exhibit C. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all shall be reported for each individual crisis service provider. This report shall be provided in a standardized format as specified by the State.

2.30.4.5 The CONTRACTOR shall submit a weekly Member CRG/TPG Assessment Report that contains information regarding the CRG assessments and TPG assessments (see Section 2.7.2.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. For purposes of this weekly Member CRG/TPG Assessment Report, the weekly report shall be due no later than 12:00 Noon, each Tuesday. The CONTRACTOR shall provide this report in the format prescribed by the State. The minimum data elements required are identified in Attachment IX, Exhibit D of this Agreement.

16. Section 2.30.4 shall be amended by adding a new 2.30.4.8 and renumbering the remaining sections.

2.30.4.8 The CONTRACTOR shall submit a quarterly Adverse Occurrences Report that summarizes all adverse occurrences and their resolutions as reported to the CONTRACTOR by its providers. This report shall be submitted in the format prescribed by TENNCARE.

17. Section 2.30.6 shall be deleted and replaced in its entirety.

2.30.6 Service Coordination Reports

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 By August 15, 2007, the CONTRACTOR shall submit an annual Case Management Services Report to TENNCARE describing the CONTRACTOR's case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the CONTRACTOR shall submit a report outlining any changes to the case management program, along with justification for such changes. These reports should only contain case management activity.

2.30.6.1.2 The CONTRACTOR shall submit a quarterly MCO Case Management Update Report that includes a brief narrative description of the MCO case management program (see Section 2.9.4); the total number of members enrolled in the MCO case management program; number of members enrolled and disenrolled in the program during the quarter; member selection criteria; the number of members who declined case management services; a description of services provided during the quarter and an evaluation of the impact of the MCO case management program during the quarter. The CONTRACTOR shall submit these reports in a format prescribed by TENNCARE. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management.

2.30.6.2 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.7).

2.30.6.3 The CONTRACTOR shall submit a quarterly Pharmacy Services Report that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.

2.30.6.4 The CONTRACTOR shall submit a Pharmacy Services Report, On Request when TENNCARE requires assistance in identifying and working with providers for any

reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

18. Section 3.4.7 shall be deleted in its entirety and subsequent sections shall be renumbered sequentially.

19. Section 3 shall be amended by adding a new Section 3.10 and renumbering the existing sections accordingly.

3.10 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

3.10.1 General

3.10.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 3.10.

3.10.1.2 Pursuant to 42 CFR 438.6, the total of all payments made to the CONTRACTOR for a year shall not exceed one hundred and five percent (105%) of capitation payments made to the CONTRACTOR..

3.10.1.3 In the first year that the incentives specified in Sections 3.10.2 and 3.10.3 below are available, the TennCare regional average HEDIS score (as calculated by TENNCARE using audited MCO HEDIS results) for each of the measures specified in Sections 3.10.2 and 3.10.3 for the last full calendar year prior to the year that the CONTRACTOR began operating under this Agreement will serve as the baseline. If complete TennCare HEDIS data for these measures is not available for the region for the year prior to the year that the CONTRACTOR began operating under this Agreement, then the last year for which complete data is available will serve as the baseline.

3.10.1.4 If NCQA makes changes in any of the measures specified in Section 3.10.2 or 3.10.3 below, such that valid comparison to prior years will not be possible, TENNCARE, at its sole discretion, may elect to either eliminate the measure from pay-for-performance incentive eligibility or replace it with another measure.

3.10.2 **Physical Health HEDIS Measures**

3.10.2.1 On July 1 of the year that the first HEDIS reports are due (see Section 2.15.6), the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 3.10.2.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 3.10.5 below).

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

3.10.2.2.1 HbA1C Testing – Diabetes measure;

3.10.2.2.2 HbA1C Control – Diabetes measure;

3.10.2.2.3 LDL-C Screening Performed – Diabetes measure;

3.10.2.2.4 Adolescent Well-Care Visits;

3.10.2.2.5 Breast Cancer Screening; and

3.10.2.2.6 Controlling High Blood Pressure.

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

3.10.3 Behavioral Health HEDIS Measures

On July 1 of the year that the first HEDIS reports are due (see Section 2.15.6) the CONTRACTOR will be eligible for a $.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year's data) for which the CONTRACTOR scores at or above the 75th national Medicaid percentile, as calculated by NCQA:

3.10.3.1 Antidepressant Medication Management; and

3.10.3.2 Follow-up Care for Children Prescribed ADHD Medication.

3.10.4 Community Tenure/Hospital Readmission for Mental Illness

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

3.10.5 NCQA Minimum Effect Size Change Methodology

The NCQA minimum effect size change methodology is as follows:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change

60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

20. Section 3.12.1.1 shall be amended by deleting and replacing the maximum liability with "One Billion, Five Hundred Seventy Three Million, Eight Hundred Thirty Eight Thousand, Thirty Six Dollars ($1,573,838,036.00)".

21. Section 4.1 shall be amended by deleting and replacing the CONTRACTOR's contact information as follows:

Eric H. Paul
Chief Executive Officer, TennCare Product
UnitedHealthcare Plan of the River Valley, Inc.
8 Cadillac Dr., Suite 410
Brentwood, TN 37027

22. Section 4.20.2.2.5 shall be deleted in its entirety and substituted with the following:

4.20.2.2.5 TENNCARE may also assess liquidated damages for failure to meet performance standards as provided in Section 2.24.3, Attachment VII, and Attachment XI of this Agreement.

23. Item A.2 in Section 4.20.2.2.7 shall be deleted in its entirety and substituted with the following:

A.2	Failure to comply with licensure requirements in Section 2.29.2 and Attachment XI of this Agreement	$5,000 per calendar day that staff/provider/driver/agent/subcontractor is not licensed as required by applicable state or local law plus the amount paid to the staff/provider/driver/agent/subcontractor during that period

24. Item B.23 in Section 4.20.2.2.7 shall be deleted in its entirety and substituted with the following:

B.23	Failure to maintain provider agreements in accordance with Section 2.12 and Attachment XI of this Agreement	$5000 per provider agreement found to be non-compliant with the requirements outlined in this Agreement

25. Section 4.20.2.2.7 shall be amended by adding a new C.6 which shall read as follows:

C.6	Failure to submit a Provider Enrollment File that meets TENNCARE's specifications (see Section 2.30.7.1)	$250 per day after the due date that the Provider Enrollment File fails to meet TENNCARE's specifications

Amendment Number 3 (cont.)

26. Attachment V shall be deleted and replaced and as follows:

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

Service Type	Service Code(s)	Geographic Access Requirement for the Service	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9	In accordance with Attachment III for Hospitals	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82	Within 100 miles of an individual's residence except in rural areas where community standards and documentation will apply	Within 30 calendar days
	Child – A9, H1, or H2	Within 100 miles of an individual's residence	Within 30 calendar days
Outpatient Mental Health Services:			
MD Services (Psychiatry)	Adult – 19 Child – B5	In accordance with Attachment IV for Psychiatry	Within 14 calendar days; if urgent, within 3 business days
Outpatient Non-MD Services	Adult – 20 Child – B6	Within 30 miles of an individual's residence	Within 14 calendar days; if urgent, within 3 business days
Intensive Outpatient*	Adult - 23, 62 Child - B7, C3	Within 60 miles of an individual's residence except in rural areas where community standards and documentation will apply	Within 14 calendar days; if urgent, within 3 business days
Inpatient, Residential & Outpatient Substance Abuse Services:			
Inpatient Facility Services	Adult – 15, 17 Child – A3, A5	Within 60 miles of an individual's residence except in rural areas where community standards and documentation will apply	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services**	Adult - 56 Child - F6	Within 100 miles of an individual's residence except in rural areas where community standards and documentation will apply	Within 14 calendar days
Outpatient Treatment Services	Adult – 27 or 28 Child – D3 or D4	Within 30 miles of an individual's residence except in rural areas where community standards and documentation will apply	Within 14 calendar days; for detoxification – within 24 hours
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1	Not subject to access standards	Within 7 calendar days
Psychiatric Rehabilitation Services:			
Psychosocial Rehabilitation***	42 or 44	Within 60 miles of an individual's residence	Within 14 calendar days
Supported Housing	32 and 33	Not Applicable****	Within 30 calendar days
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1	Not subject to access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Behavioral Health Crisis Services			

Amendment Number 3 (cont.)

Crisis Stabilization	Adult – 41	Not subject to access standards	Within 4 hours of referral

*Intensive Outpatient services may equal Adult Day Treatment, Intensive Day Treatment Program for Children & Adolescents or Partial Hospitalization.

**24 Hour Residential Treatment Substance Abuse Services may be provided by facilities licensed by the Tennessee Department of Health as Halfway House Treatment Facilities (DOH Rule Chapter 1200-8-17), Residential Detoxification Treatment Facilities (DOH Rule Chapter 1200-8-22) or Residential Rehabilitation Treatment Facilities (DOH Rule Chapter 1200-8-23). (Effective 1/1/2008, the Tennessee Department of Mental Health and Developmental Disabilities will license these facilities.)

***Psychosocial Rehabilitation is a consumer-centered program of services for adult recipients to enhance and support the process of recovery and may include Supported Employment, Illness Management & Recovery and Peer Support services. ((TDMHDD Rule Chapter 1940-5-29)

****Placement of an individual more than 60 miles from his/her residence must be prior approved by the member or his/her legally appointed representative.

All providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient Mental Health Services:	
MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult - 23, 62 Child - B7, C3
Inpatient, Residential & Outpatient Substance Abuse Services:	
Inpatient Facility Services	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services	Adult - 56 Child - F6
Outpatient Treatment Services	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Behavioral Health Crisis Services	
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1

Amendment Number 3 (cont.)

Crisis Respite	Adult – 40 Child – B2
Crisis Stabilization	Adult – 41

Amendment Number 3 (cont.)

27. Attachment VII shall be amended by adding a new item 7, deleting and replacing the re-numbered Item 9, adding a new Item 10 and renumbering all of the Performance Measures as appropriate, including all references thereto.

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
7	Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	100% of contract providers on the Provider Enrollment File have a signed provider agreement with the CONTRACTOR	Providers listed on Provider Enrollment file with an "In Plan" indicator must have a signed agreement	Upon TENNCARE request	$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR

Amendment Number 3 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Specialist Provider Network	Provider Enrollment File	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology 2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service 3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s) 2. Center of Excellence for Behavioral Health: Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

Amendment Number 3 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
9	Provider Participation Accuracy	Provider Enrollment File	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Quarterly	$25,000 per quarter if less than 90% of listed providers confirm participation. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or waived if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers in the sample are participating
10	Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of listed providers is incorrect for each data element	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for each element as determined by TENNCARE	Quarterly	$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for each data element $25,000 per quarter if data for more than 30% of providers is incorrect for each data element The $25,000 liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation

Amendment Number 3 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
11	Distance from provider to member	Provider Enrollment File	In accordance with this Agreement, including Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

28. Attachment VIII shall be amended by adding "Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI" after item 175.

29. Attachment IX, Exhibit C shall be deleted and replaced in its entirety.

ATTACHMENT IX, EXHIBIT C

BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

The Behavioral Health Crisis Response Report required in Section 2.30.4.4 shall include, at a minimum, the following data elements:

1. Total Telephone Contacts
2. Type of Call: Psychiatric Emergency
3. Type of Call: Urgent
4. Type of Call: Routine
5. Total Face-to-Face Contacts
6. Face-to-Face Type: Psychiatric Emergency
7. Face-to-Face Type: Urgent
8. Face-to-Face Type: Routine
9. Total Face-to-Face Contacts by Payor
10. Face-to-Face Payor Source: TennCare
11. Face-to-Face Payor Source: Medicare
12. Face-to-Face Payor Source: Commercial
13. Face-to-Face Payor Source: None
14. Total Face-to-Face Contacts by Location
15. Face-to-Face Location: Onsite at CMHA
16. Face-to-Face Location: ER
17. Face-to-Face Location: Other Offsite
18. Total Face-to-Face Contacts by Disposition
19. Disposition: Total Admitted to RMHI (acute)
20. # Admitted to RMHI Not Mandatory Pre-Screened
21. Disposition: Total Admitted to Other Inpt (acute) Includes Dual Dx
22. # Admitted To Other Inpt Not Mandatory Pre-Screened

Amendment Number 3 (cont.)

23. GRAND TOTAL PSYCHIATRIC ADMISSIONS
24. Disposition: Admitted to IP SA Treatment
25. Disposition: Referred to Lower Level OP Care
26. Disposition: Referred to Respite Services
27. Average time for Admission to Crisis Respite (only when admitted to respite)
28. Disposition: Referred to Other Services
29. Disposition: Assessed / No Need for Referral
30. Disposition: Consumers Refusing Referral
31. Total Number of Face-to-Face Contacts for C&A <18 yrs of age
32. Total Number of Face-to-Face Contacts for C&A 18 to <21 yrs of age
33. Total Number of Face-to-Face Contacts for Adults 21 yrs and older
34. Total Number of Behavioral Health Providers notified of Crisis (only if consumer has a provider)
35. Average Time of Arrival in Minutes: Psychiatric Emergency
36. Average Time of Arrival in Minutes: Urgent
37. Barriers to Diversion: No Psychiatric Respite Accessible
38. Barriers to Diversion: No SA/Dual Respite Accessible
39. Barriers to Diversion: Consumer/Guardian Refused Respite
40. Barriers to Diversion: 6-404 Signed Prior to Assessment (when consumer could have been diverted if CON not signed)
41. Barriers to Diversion: Lack of Linkage w/Case Mgr (only if consumer has a CM)
42. Barriers to Diversion: Other (only for inappropriate admissions and barrier does not fit in any other category)

30. Attachment XI shall be renamed Attachment XII, and a new Attachment XI shall be inserted to read as follows:

ATTACHMENT XI
NEMT REQUIREMENTS

A.1 GENERAL

A.1.1 The CONTRACTOR, in its delivery of NEMT services, shall comply with all of the requirements in this Attachment XI. The requirements in this Attachment are in addition to, not instead of, requirements found elsewhere in the Agreement.

A.1.2 The CONTRACTOR shall develop written policies and procedures that describe how the CONTRACTOR, in the delivery of NEMT services, shall comply with the requirements of the Agreement, including this Attachment. Pursuant to Section 2.25.4 of the Agreement, TENNCARE will specify the policies and procedures that must be prior approved in writing by TENNCARE. As part of its policies and procedures the CONTRACTOR shall develop an operating procedures manual detailing procedures for meeting, at a minimum, requirements regarding the following:

A.1.2.1 Requesting NEMT services (see Section A.3 of this Attachment);

A.1.2.2 Approving NEMT services (see Section A.4 of this Attachment); and

A.1.2.3 Scheduling, assigning and dispatching trips (see Section A.5 of this Attachment).

A.2 NEMT IMPLEMENTATION WORK PLAN AND READINESS REVIEW

A.2.1 The CONTRACTOR shall prepare and maintain throughout the implementation period (defined as the period from April 1, 2008 through July 31, 2008) an implementation work plan that details all of the tasks required to successfully implement all of the NEMT requirements of the Agreement, including this Attachment XI, by September 1, 2008. The CONTRACTOR shall submit the final implementation work plan to TENNCARE for prior written approval no later than April 1, 2008. By September 1, 2008, the CONTRACTOR shall have fully implemented the implementation work plan, and the CONTRACTOR may be subject to liquidated damages for failure to comply with the provisions herein.

A.2.2 Prior to implementation of the NEMT requirements in this Attachment, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that, in its delivery of NEMT services, the CONTRACTOR is able to meet all of the NEMT requirements of the Agreement, including but not limited to this Attachment XI.

A.2.3 The CONTRACTOR shall cooperate in a "readiness review" conducted by TENNCARE to review the CONTRACTOR's readiness to begin providing NEMT services in accordance with the Agreement. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all NEMT requirements of the Agreement as determined by TENNCARE.

A.2.4 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

A.3 REQUESTING NEMT SERVICES

A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member's DCS liaison, foster parent, adoptive parent, or provider.

A.3.2 Requests for NEMT services should be made at least seventy-two (72) hours before the NEMT service is needed. However, this timeframe does not apply to urgent trips (see Section A.5.7 of this Attachment), scheduling changes initiated by the provider, and follow-up appointments when the timeframe does not allow advance scheduling. In addition, the CONTRACTOR shall accommodate requests for NEMT services that are made within the following timeframes: three (3) hours before the NEMT service is needed when the pick-up address is in an urban area and four (4) hours before the NEMT service is needed when the pick-up address is in a non-urban area. The CONTRACTOR shall provide additional education to members who fail to request transportation seventy-two (72) hours before the NEMT service is needed (see Section A.10 of this Attachment).

A.3.3 The CONTRACTOR shall not have a time limit for scheduling transportation for future appointments. For example, if a member calls to schedule transportation to an appointment that is scheduled in two (2) months, the CONTRACTOR shall arrange for that transportation and shall not require the member to call back at a later time.

A.4 APPROVING NEMT SERVICES

A.4.1 General

A.4.1.1 Transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to member's age or lack of accompanying adult. Any decision to deny transportation of a minor child due to a member's age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The age of consent for children with mental illness is sixteen (16) (see TCA 33-8-202).

A.4.1.2 As part of the approval process, the CONTRACTOR shall:

A.4.1.2.1 Collect relevant information from the caller and enter it into the CONTRACTOR's system (see Section A.5.10 of this Attachment);

A.4.1.2.2 Verify the member's eligibility for NEMT services;

A.4.1.2.3 Determine the appropriate mode of transportation for the member;

A.4.1.2.4 Determine the appropriate level of service for the member;

A.4.1.2.5 Approve or deny the request; and

A.4.1.2.6 Enter the appropriate information into the CONTRACTOR's system (see Section A.5.10 of this Attachment).

A.4.2 **Verifying Eligibility for NEMT Services**

A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:

A.4.2.1.1 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR's MCO;

A.4.2.1.2 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment); and

A.4.2.1.3 That the transportation is a covered NEMT service (see Section 2.6.1.2 of the Agreement).

A.4.3 **Determining the Appropriate Mode of Transportation**

A.4.3.1 General

A.4.3.1.1 If the criteria in Section A.4.2 of this Attachment are met, the CONTRACTOR shall determine what mode of transportation is appropriate to meet the needs of the member. The modes of transportation that shall be covered by the CONTRACTOR include, but are not limited to: fixed route, multi-passenger van, wheelchair van, invalid vehicle, and ambulance.

A.4.3.1.2 In order to determine the appropriate mode of transportation, the CONTRACTOR shall:

A.4.3.1.2.1 Determine whether the member is ambulatory and the member's current level of mobility and functional independence;

A.4.3.1.2.2 Determine whether the member will be accompanied by an escort, and, if so, whether the member requires assistance and whether the escort meets the requirements for an escort (see TennCare rules and regulations);

A.4.3.1.2.3 Determine whether a member is under the age of eighteen (18) and will be accompanied by an adult; and

A.4.3.1.2.4 Assess any special conditions or needs of the member, including physical or mental disabilities.

A.4.3.2 Fixed Route

A.4.3.2.1 The CONTRACTOR shall utilize fixed route transportation whenever available and appropriate to meet the needs of the member.

A.4.3.2.2 The CONTRACTOR shall be familiar with schedules of fixed route transportation in communities where it is available and where it becomes available during the term of the Agreement.

A.4.3.2.3 The CONTRACTOR shall distribute and/or arrange for the distribution of fixed route tickets, tokens or passes to members for whom fixed route transportation is available and appropriate. The CONTRACTOR shall have controls in place to track the distribution of tickets/tokens/passes. The CONTRACTOR shall use best efforts that tickets/tokens/passes are used appropriately.

A.4.3.2.4 The CONTRACTOR shall consider the following when determining whether fixed route transportation is available and appropriate for a member:

A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-quarter (1/4th) of a mile;

A.4.3.2.4.2 The member shall not be required to change buses/trolleys more than once each leg of the trip;

A.4.3.2.4.3 Using fixed route transportation shall not increase travel time more than sixty (60) minutes as compared to transportation directly from the pick-up location to the drop-off destination;

A.4.3.2.4.4 The fixed route transportation schedule shall allow the member to arrive at the destination no more than sixty (60) minutes prior to the scheduled appointment time and shall be flexible on the return so that the member does not have to wait at the pick-up location more than sixty (60) minutes after the estimated time the appointment will end;

A.4.3.2.4.5 Whether fixed route transportation is appropriate based on the member's physical or mental disabilities; and

A.4.3.2.4.6 Whether using fixed route for the requested trip is appropriate considering the accessibility of the stops and the safety in accessing the stops.

A.4.3.2.5 Fixed route shall not be appropriate for a member whose physician states in writing that the member cannot use fixed route transportation.

A.4.3.3 <u>Ambulance</u>

The CONTRACTOR's policies and procedures regarding the appropriateness of using an ambulance to provide covered NEMT services shall be based on Medicare's medical necessity requirements (see, e.g., 42 CFR 410.40 and Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services).

A.4.4 **Determining Level of Service**

A.4.4.1 The CONTRACTOR shall assess the member's needs to determine whether the member requires curb-to-curb, door-to-door, or hand-to-hand service (as these terms are defined in Exhibit A of this Attachment).

A.4.4.2 The CONTRACTOR may require a medical certification statement from the member's provider in order to approve door-to-door or hand-to-hand service. Medical certification shall be completed within the timeframes specified in Section A.5.1.3 of this Attachment.

A.4.4.3 The CONTRACTOR shall ensure that members receive the appropriate level of service.

A.4.4.4 Failure to comply with requirements regarding level of service may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.4.5 **Standing Orders**

A.4.5.1 Except as provided in this Section A.4.5, the approval of Standing Orders by the CONTRACTOR shall be consistent with the requirements in Sections A.4.1 through A.4.4.

A.4.5.2 In order to approve a Standing Order (as defined in Exhibit A of this Attachment), the CONTRACTOR shall, at a minimum, call the provider to verify the series of appointments. The CONTRACTOR may, at its discretion, require that the member's provider certify the series of appointments in writing.

A.4.5.3 The CONTRACTOR shall approve Standing Orders consistent with the series of appointments. For example, if the member has a series of appointments over six (6) months, the CONTRACTOR shall approve transportation for each trip, including all legs of the trip, for the six (6) months. However, the CONTRACTOR shall verify the member's eligibility prior to each pick-up. The CONTRACTOR may verify additional information before each pick-up as necessary.

A.4.6 **Validating Requests**

A.4.6.1 The CONTRACTOR may conduct random pre-transportation validation checks prior to approving the request in order to prevent fraud and abuse.

A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.

A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.

A.4.6.4 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.3 of this Attachment.

A.5 SCHEDULING, ASSIGNING, AND DISPATCHING TRIPS

A.5.1 General

A.5.1.1 The CONTRACTOR shall ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider.

A.5.1.3 The CONTRACTOR shall approve and schedule or deny a request for transportation (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for his/her appointment. Failure to comply with this requirement may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.1.4 The CONTRACTOR shall ensure that trips are dispatched appropriately and meet the requirements of this Attachment. The dispatcher shall, at minimum, provide updated information to drivers, monitor drivers' locations, and resolve pick-up and delivery issues.

A.5.2 Multi-Passenger Transportation

A.5.2.1 The CONTRACTOR may group enrollees and trips (or legs of trips) to promote efficiency and cost effectiveness. The CONTRACTOR may contact providers if necessary to coordinate multi-passenger transportation.

A.5.2.2 For multi-passenger trips, the CONTRACTOR shall schedule each trip leg so that a member does not remain in the vehicle for more than one (1) hour longer than the average travel time for direct transportation of that member.

A.5.3 Choice of NEMT Provider

The CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member's request to have or not have a specific NEMT provider or driver.

A.5.4 **Notifying Members of Arrangements**

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.3 of this Attachment) and prior to the date of the NEMT service. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

A.5.5 **Notifying NEMT Providers**

A.5.5.1 The CONTRACTOR shall provide a trip manifest to each NEMT provider no later than the NEMT provider's close of business the day before the date of the NEMT service.

A.5.5.2 The CONTRACTOR shall have the ability to send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. The CONTRACTOR shall ensure that provision of the trip manifest is in compliance with HIPAA requirements (see Section 2.27 of the Agreement). The CONTRACTOR shall have dedicated telephone lines available at all times for faxing purposes.

A.5.5.3 The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip, including but not limited to the information listed in Exhibit B of this Attachment.

A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone or electronically to confirm that the trip will be accepted.

A.5.5.5 The CONTRACTOR shall communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary trips.

A.5.6 **Accommodating Scheduling Changes**

A.5.6.1 The CONTRACTOR shall accommodate unforeseen schedule changes and shall timely assign the trip to another NEMT provider if necessary.

A.5.6.2 The CONTRACTOR shall ensure that neither NEMT providers nor drivers change the assigned pick-up time without permission from the CONTRACTOR.

A.5.7 **Urgent Trips**

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.8 **Adverse Weather Plan**

The CONTRACTOR shall have policies and procedures for transporting members who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall. The policies and procedures shall include, at a minimum, staff training, methods of notification, and member education.

A.5.9 **Contingency and Back-Up Plans**

The CONTRACTOR shall have policies and procedures that describe contingency plans for unexpected peak transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service.

A.5.10 **Approval and Scheduling System Features**

A.5.10.1 Each transportation request processed by the CONTRACTOR shall be assigned a unique number, shall contain all pertinent information about the request, and shall be available to NEMT Call Center staff. This information shall include, but not be limited to the following:

A.5.10.1.1 Verification of member's TennCare eligibility (e.g., member name, address, Medicaid ID number, and telephone number if available; eligibility start and end dates);

A.5.10.1.2 Determination that service is a TennCare covered service (e.g., category of service) (see Section A.4.2 of this Attachment);

A.5.10.1.3 Determination that the transportation is a covered NEMT service (see Section A.4.2 of this Attachment);

A.5.10.1.4 Determination of the appropriate mode of transportation (e.g., member's requested mode of transportation, member's special needs, availability and appropriateness of fixed route, the approved mode of transportation, justification for the approved mode of transportation);

A.5.10.1.5 Determination of the appropriate level of service (see Section A.4.4 of this Attachment);

A.5.10.1.6 Information regarding Standing Orders (if applicable) (see Section A.4.5 of this Attachment);

A.5.10.1.7 Information about whether the request was modified, approved or denied and how the member was notified;

A.5.10.1.8 Information about approved and scheduled transportation (e.g., elements required for the trip manifest; see Section A.5.5 of this Attachment);

A.5.10.1.9 Whether the request was validated;

A.5.10.1.10 Timeframes for the approval process (e.g., date and time of request, determination, scheduling, and notification of member); and

A.5.10.1.11 If applicable, reason for trip cancellation.

A.5.10.2 The CONTRACTOR's approval and scheduling systems shall be coded such that policies and procedures are applied consistently.

A.5.10.3 Based on approval of previous NEMT services, the CONTRACTOR shall display members' permanent and temporary special needs, appropriate mode of transportation, and any other information necessary to ensure that appropriate transportation is approved and provided. All of this information shall be easily accessible by all NEMT Call Center staff.

A.5.10.4 The CONTRACTOR's approval and scheduling systems shall also support the following:

A.5.10.4.1 A database of NEMT providers that includes information needed to determine trip assignments such as but not limited to: types of vehicles, number of vehicles by type, lift capacity of vehicles, and geographic coverage.

A.5.10.4.2 Automatic address validations, distance calculations and trip pricing, if applicable;

A.5.10.4.3 Ability to generate a trip manifest (see Section A.5.5 of this Attachment);

A.5.10.4.4 Standing Order and Single Trip (as defined in Exhibit A of this Attachment) reservation capability; and

A.5.10.4.5 Ability to determine if fixed route transportation is available and appropriate for the member.

A.5.10.5 The CONTRACTOR's approval and scheduling system shall enable report and data submission as specified in the Agreement.

A.6 PICK-UP AND DELIVERY STANDARDS

A.6.1 The CONTRACTOR shall ensure that NEMT providers arrive on time for scheduled pick-ups. The NEMT provider may arrive before the scheduled pick-up time, but the member shall not be required to board the vehicle prior to the scheduled pick-up time.

A.6.2 The CONTRACTOR shall ensure that drivers make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver shall notify the dispatcher before departing from the pick-up location.

A.6.3 The CONTRACTOR shall ensure that drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).

A.6.4 The CONTRACTOR shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return

leg of the trip, the CONTRACTOR shall ensure that members are picked up within one (1) hour after notification.

A.6.5 The CONTRACTOR shall ensure that the average waiting time for members for pick-up does not exceed ten (10) minutes past the scheduled pick-up time.

A.6.6 The CONTRACTOR shall ensure that if the driver will not arrive on time to the pick-up location, the driver shall notify the dispatcher, and the member is contacted.

A.6.7 The CONTRACTOR shall ensure that if the driver will not arrive on time to an appointment, the driver shall notify the dispatcher, and the provider is contacted.

A.6.8 The driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person's standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. The CONTRACTOR shall ensure that if a driver refuses to transport a member the driver immediately notifies the dispatcher, and the dispatcher notifies the CONTRACTOR.

A.6.9 The CONTRACTOR shall ensure that in the event of an incident or accident (see Section A.17.2 of this Attachment), the driver notifies the dispatcher immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. The CONTRACTOR shall ensure that it is promptly notified of any incident or accident.

A.6.10 Failure to comply with requirements regarding pick-up and delivery standards may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.7 VEHICLE STANDARDS

A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards.

A.7.2 The CONTRACTOR shall ensure that all vehicles comply with the vehicle requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements in this Section, and the requirements in Exhibit C of this Attachment.

A.7.3 The CONTRACTOR shall ensure that any vehicle used to cross a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

A.7.4 The CONTRACTOR shall ensure that each vehicle has a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute for this requirement.

A.7.5 The CONTRACTOR shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

A.7.6 The CONTRACTOR shall ensure that, at minimum, all vehicles providing stretcher transport are owned and operated by an entity licensed by the Tennessee Department of Health (DOH) to provide invalid

services, have an active valid permit issued by DOH as a ground invalid vehicle, and comply with DOH's requirements for ground invalid vehicles.

A.7.7 The CONTRACTOR shall ensure that, except as otherwise permitted by State of Tennessee law, all ambulances are owned and operated by an entity licensed by DOH to provide ambulance services, have an active valid ambulance permit from DOH, and comply with DOH's requirements for ambulances. The CONTRACTOR shall also ensure that vehicles comply with any applicable local requirements.

A.7.8 As required in Section A.17 of this Attachment, the CONTRACTOR shall inspect all vehicles (except fixed route, invalid vehicles, and ambulances) for compliance with applicable requirements and shall immediately remove any vehicle that is out of compliance.

A.7.9 Failure to comply with requirements regarding vehicle standards may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.8 TRAINING AND STANDARDS FOR DRIVERS

A.8.1 The CONTRACTOR shall ensure that all drivers receive appropriate training and meet applicable standards, as specified in this Section A.8. These requirements do not apply to drivers of fixed route transportation. Drivers of fixed route transportation shall comply with all rules, regulations, policies and procedures promulgated by the fixed route carrier, federal, state or local law.

A.8.2 Driver Training

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training.

A.8.2.2 Driver training shall include, at a minimum the following:

A.8.2.2.1 Customer service;

A.8.2.2.2 Passenger assistance;

A.8.2.2.3 Sensitivity training;

A.8.2.2.4 Mental health and substance abuse issues;

A.8.2.2.5 Title VI requirements (Civil Rights Act of 1964);

A.8.2.2.6 HIPAA privacy requirements;

A.8.2.2.7 ADA requirements;

A.8.2.2.8 Wheelchair securement/safety;

A.8.2.2.9 Seat belt usage and child restraints;

A.8.2.2.10 Handling and reporting accidents and incidents;

A.8.2.2.11 Emergency evacuation;

A.8.2.2.12 Daily vehicle inspection;

A.8.2.2.13 Defensive driving;

A.8.2.2.14 Risk management;

A.8.2.2.15 Communications;

A.8.2.2.16 Infection control;

A.8.2.2.17 Annual road tests; and

A.8.2.2.18 Reporting enrollee and provider fraud and abuse.

A.8.3 **Standards for Drivers**

A.8.3.1 The CONTRACTOR shall ensure that all drivers comply with driver requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements of this Section, and the requirements in Exhibit D of this Attachment.

A.8.3.2 The CONTRACTOR shall ensure that all drivers are at least eighteen (18) years of age and have a Class D driver license with F (for hire endorsement) or commercial driver license (Class A, B, or C) issued by the State of Tennessee or the equivalent licensure issued by the driver's state of residence.

A.8.3.3 The CONTRACTOR shall ensure that all drivers meet the State of Tennessee requirements regarding proof of financial responsibility and/or insurance.

A.8.3.4 The CONTRACTOR shall ensure that any driver that crosses a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

A.8.3.5 The CONTRACTOR shall ensure that any personnel contracted by or employed by a NEMT provider to provide medical assistance to a member during a non-emergency ambulance trip is licensed by the State of Tennessee as an emergency medical technician (EMT) and complies with DOH requirements for EMTs.

A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers.

A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol or drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding

use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers.

A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. In addition, the CONTRACTOR shall ensure that random national criminal background checks are conducted. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement.

A.8.3.9 The CONTRACTOR shall ensure that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the Agreement.

A.8.3.10 The CONTRACTOR shall ensure that no driver has been convicted of a criminal offense related to the driver's involvement with Medicare, Medicaid, or the federal Title XX services program (see Section 1128 of the Social Security Act and 42 CFR 455.106).

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry or the equivalent registry in the state of the driver's residence prior to providing services under the Agreement and every five (5) years thereafter.

A.8.3.12 The CONTRACTOR shall ensure that drivers pass a national driver license background check prior to providing services under the Agreement. This initial national driver license background check shall, at a minimum, show the following:

A.8.3.12.1 No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;

A.8.3.12.2 No conviction for reckless driving within the previous thirty-six (36) month period;

A.8.3.12.3 No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;

A.8.3.12.4 No conviction for a felony involving the use of an automobile within the previous thirty-six (36) months;

A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous thirty-six (36) months;

A.8.3.12.6 Conviction for no more than one (1) at-fault accident resulting in personal injury or property damage within the previous thirty-six (36) months; and

A.8.3.12.7 Not have a combination of conviction for one (1) at-fault accident resulting in personal injury or property damage and conviction for one (1) unrelated minor moving traffic violation within the previous thirty-six (36) months.

A.8.3.13 The CONTRACTOR shall ensure that drivers pass an annual national driver license background check. The annual check shall, at a minimum, show the following:

A.8.3.13.1 No conviction for a major moving traffic violation such as driving while intoxicated, driving under the influence, or reckless driving;

A.8.3.13.2 No conviction for leaving the scene of a personal injury or fatal accident;

A.8.3.13.3 No conviction for a felony involving the use of an automobile;

A.8.3.13.4 No more than two (2) convictions for minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle;

A.8.3.13.5 No more than one (1) conviction for an at-fault accident resulting in personal injury or property damage; and

A.8.3.13.6 Not have a combination of one (1) conviction for an at-fault accident resulting in personal injury or property damage and one (1) conviction for an unrelated minor moving traffic violation.

A.8.3.14 The CONTRACTOR shall require that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR of any moving traffic violation or if a driver's license is suspended or revoked.

A.8.3.15 The CONTRACTOR shall ensure that all ambulance drivers and invalid vehicle drivers comply with applicable DOH and local requirements.

A.8.3.16 The CONTRACTOR shall require that drivers maintain daily transportation logs containing, at a minimum, the information listed in Exhibit E of this Attachment.

A.8.3.17 As required in Section A.17 of this Attachment, the CONTRACTOR shall monitor drivers and immediately remove any driver that is out of compliance with applicable requirements.

A.8.4 Failure to comply with requirements regarding driver training and driver standards may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.9 NEMT CALL CENTER

A.9.1 The CONTRACTOR shall maintain a NEMT Call Center to handle requests for NEMT services as well as questions, comments, and inquiries from members and their representatives, NEMT providers, and providers regarding NEMT services. The NEMT Call Center may use the same infrastructure as the CONTRACTOR's member services line, but the CONTRACTOR shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.

A.9.2 The NEMT Call Center shall be appropriately staffed twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year to handle the call volume in compliance with the

performance standards in Section A.9.6 of this Attachment. The CONTRACTOR shall ensure continuous availability of NEMT Call Center services.

A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as the there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.

A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an after hours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message.

A.9.5 The CONTRACTOR's NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller's phone number is not blocked.

A.9.6 The CONTRACTOR shall have the capability of making outbound calls.

A.9.7 The CONTRACTOR shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed in accordance with the requirements of this Section A.9 and the following performance standards for each line or queue:

A.9.7.1 Blocked calls – No more than one percent (1%) of calls are blocked;

A.9.7.2 Answer rate – At least ninety percent (90%) of all calls are answered by a live voice within thirty (30) seconds;

A.9.7.3 Abandoned calls – No more than five percent (5%) of calls are abandoned; and

A.9.7.4 Hold time – Average hold time, including transfers to other CONTRACTOR staff, is no more than three (3) minutes.

A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call.

A.9.9 The CONTRACTOR shall have qualified bi-lingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers who, at a minimum, speak Spanish, The CONTRACTOR shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.

A.9.10 The CONTRACTOR's NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.

A.9.11 The CONTRACTOR shall operate an automatic call distribution system for its NEMT Call Center.

A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider queue.

A.9.13 The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt.

A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member's eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by TENNCARE.

A.9.15 The CONTRACTOR shall advise callers that calls to the NEMT Call Center are monitored and recorded for quality assurance purposes.

A.9.16 The CONTRACTOR shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity and training purposes.

A.9.17 The CONTRACTOR shall monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff member on a monthly basis. The CONTRACTOR shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. The CONTRACTOR shall use this monitoring to identify problems or issues, for quality control, and for training purposes. The CONTRACTOR shall document and retain results of this monitoring and subsequent training.

A.9.18 The CONTRACTOR's NEMT Call Center system shall be able to produce the reports specified in Section A.19 of this Attachment as well as on request and ad hoc reports that TENNCARE may request.

A.9.19 The CONTRACTOR shall analyze data collected from its NEMT Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Agreement, and ensure adequate resources and staffing.

A.9.20 Failure to comply with requirements regarding the NEMT Call Center may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.10 NEMT MEMBER EDUCATION

A.10.1 The CONTRACTOR shall develop materials to inform and educate members about NEMT services.

A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, and Standing Orders.

A.10.3 All written materials shall comply with Section 2.17 of the Agreement and must be prior approved in writing by TENNCARE.

A.10.4 Prior to the date of implementation, as specified by TENNCARE, the CONTRACTOR shall mail member education materials to its members by first class mail and at the CONTRACTOR's expense.

A.11 NON-COMPLIANT MEMBERS

A.11.1 The CONTRACTOR shall provide targeted education to members who do not comply with the CONTRACTOR's policies and procedures regarding NEMT services. All member materials shall comply with Section 2.17 of the Agreement and must be prior approved in writing by TENNCARE.

A.11.2 The CONTRACTOR shall not take any action to sanction members who do not comply with the CONTRACTOR's policies and procedures.

A.11.3 Members shall not be charged for no-shows (as defined in Exhibit A of this Attachment).

A.12 NEMT PROVIDER NETWORK

A.12.1 The CONTRACTOR shall establish a network of qualified NEMT providers to provide covered NEMT services to meet the transportation needs of members. In developing its network of qualified NEMT providers the CONTRACTOR shall comply with Section 2.11.1 of the Agreement.

A.12.2 The CONTRACTOR shall have sufficient NEMT providers in its network (numbers and types of vehicles and drivers) so that the failure of any NEMT provider to perform will not impede the ability of the CONTRACTOR to provide NEMT services in accordance with the requirements of the Agreement.

A.12.3 The CONTRACTOR shall ensure that its NEMT providers have a sufficient number of vehicles and drivers available to meet the timeliness requirements of the Agreement (see Section A.5 of this Attachment).

A.12.4 The CONTRACTOR shall provide Human Resource Agencies (HRAs) the opportunity to become a NEMT provider if the HRA is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers and include alternative indemnification language as specified in Section A.13.4 of this Attachment.

A.12.5 The CONTRACTOR shall provide Division of Mental Retardation Services (DMRS) waiver providers (defined as providers who have signed a provider agreement with DMRS and the Bureau of TennCare to provide residential treatment services or day services through a HCBS waiver for individuals with mental retardation) the opportunity to become a NEMT provider if the provider is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers. These providers shall only provide covered NEMT services to members receiving HCBS waiver services from the provider. The State reimburses these providers for transportation services to/from HCBS waiver services. However, the State does not reimburse these providers for transportation to/from other TennCare covered services. The CONTRACTOR shall reimburse these providers for covered NEMT to TennCare covered services that are not being provided to the member though a HCBS waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. This includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

A.12.7 The CONTRACTOR's NEMT provider network must be prior approved in writing by TENNCARE and shall be subject to ongoing review and approval by TENNCARE. Failure to comply with NEMT provider network requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

A.13 NEMT PROVIDER AGREEMENTS

A.13.1 All NEMT provider agreements shall comply with applicable requirements of the Agreement, including but not limited to prior written approval of template agreements and revisions thereto by the Tennessee Department of Commerce and Insurance (TDCI).

A.13.2 Except for fixed route, NEMT providers used for contingency or back-up (see Section A.5.9 of this Attachment), or as otherwise agreed to by TENNCARE in writing, the CONTRACTOR shall not use transportation providers with which the CONTRACTOR has not executed a provider agreement.

A.13.3 In addition to the requirements in other sections of the Agreement, all NEMT provider agreements shall meet the following minimum requirements:

A.13.3.1 Include provisions related to payment for cancellations (see Section A.5.5.5 of this Attachment), no-shows (as defined in Exhibit A to this Attachment), escorts, and adults accompanying members under age eighteen (18);

A.13.3.2 Specify the services to be provided by the NEMT provider, including, as applicable, mode(s) of transportation and dispatching.

A.13.3.3 Include expectations for door-to-door, hand-to-hand, and curb-to-curb service (see Section A.4.4 of this Attachment and definitions in Exhibit A of this Attachment);

A.13.3.4 Include or reference trip manifest requirements (see Section A.5.5 of this Attachment);

A.13.3.5 Include urgent trip requirements (see Section A.5.7 of this Attachment);

A.13.3.6 Include or reference back-up service requirements (see Section A.5.9 of this Attachment);

A.13.3.7 Include or reference pick-up and delivery standards (see Section A.6 of this Attachment);

A.13.3.8 Require the NEMT provider to notify the CONTRACTOR of specified events, including no-shows (see Section A.6.2 of this Attachment), accidents, moving traffic violations, and incidents (see Section A.6.9 of this Attachment);

A.13.3.9 Include or reference vehicle standards (see Section A.7 of this Attachment);

A.13.3.10 Require the NEMT provider to notify the CONTRACTOR if a vehicle is out of service or otherwise unavailable;

A.13.3.11 Include or reference training requirements for the NEMT provider (see Section A.16.2 of this Attachment) and for drivers (see Section A.8.2 of this Attachment);

A.13.3.12 Include or reference driver standards (see Section A.8.3), including driver log requirements (see Section A.8.3.16 of this Attachment) and require the NEMT provider to provide copies of driver logs to the CONTRACTOR upon request; and

A.13.3.13 Require the NEMT provider to secure and maintain adequate insurance coverage prior to providing any NEMT services under the Agreement, including, at minimum, the following:

A.13.3.13.1 Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars ($1,000,000) per occurrence for employers' liability whichever is greater;

A.13.3.13.2 Comprehensive Commercial General Liability (including personal injury and property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the aggregate; and

A.13.3.13.3 Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence.

A.13.4 If the CONTRACTOR has a provider agreement with a HRA, the agreement shall meet the requirements specified in Sections A.13.1 and A.13.3 above and shall also include indemnification language negotiated with the HRA and prior approved in writing by TENNCARE as an alternative to the indemnification language referenced in the Agreement.

A.13.5 Failure to comply with provider agreement requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

A.14 PAYMENT FOR NEMT SERVICES

A.14.1 General

In addition to requirements in the Agreement regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment.

A.14.2 Payment for Fixed Route

A.14.2.1 The CONTRACTOR shall make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.

A.14.2.2 If the CONTRACTOR cannot provide tickets/token/passes prior to the scheduled transportation, the CONTRACTOR shall offer the member the choice of having the CONTRACTOR arrange alternate transportation or reimbursing the member for the cost of the applicable fare for the fixed route transportation approved by the CONTRACTOR.

A.14.2.3 The CONTRACTOR may negotiate agreements with fixed route transportation entities. Such agreements must be prior approved in writing by TENNCARE.

A.14.3 **Validation Checks**

A.14.3.1 The CONTRACTOR shall have policies and procedures for conducting random post-transportation validation checks. These policies and procedures must be prior approved in writing by TENNCARE. These policies and procedures shall specify how the CONTRACTOR will conduct post-transportation validation checks (e.g., by calling providers or matching NEMT claims and physical health/behavioral health claims), the frequency of the checks (e.g., one point five percent (1.5%) of NEMT claims received in a month), and any follow-up activities (e.g., if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before a trip is approved (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement.

A.14.3.2 The CONTRACTOR shall perform post-transportation validation checks for fixed route transportation as specified in the CONTRACTOR's policies and procedures, which must be prior approved in writing by TENNCARE.

A.15 **NEMT CLAIMS MANAGEMENT**

A.15.1 The CONTRACTOR shall process NEMT provider claims consistent with the claims management requirements of the Agreement.

A.15.2 The CONTRACTOR shall submit encounter data for NEMT services that meets the requirements in the Agreement, including compliance with HIPAA's electronic transactions and code set requirements.

A.15.3 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

A.15.4 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

A.15.5 The CONTRACTOR shall pay ninety-seven percent (97%) of NEMT claims accurately upon initial submission.

A.15.6 The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Agreement regarding a claims payment accuracy audit.

A.15.7 Failure to comply with requirements regarding NEMT claims management may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.16 NEMT PROVIDER MANUAL AND NEMT PROVIDER EDUCATION AND TRAINING

A.16.1 NEMT Provider Manual

A.16.1.1 The CONTRACTOR shall issue a NEMT provider manual to all NEMT providers. The CONTRACTOR may distribute the NEMT provider manual electronically (e.g., through its website) so long as NEMT providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the NEMT provider.

A.16.1.2 The NEMT provider manual must be prior approved in writing by TENNCARE and shall include, at a minimum, the following:

A.16.1.2.1 Description of the TennCare program;

A.16.1.2.2 Covered and non-covered NEMT services, including requirement that transportation must be to a TennCare covered service;

A.16.1.2.3 Prior approval requirements;

A.16.1.2.4 Vehicle requirements;

A.16.1.2.5 Driver requirements;

A.16.1.2.6 Protocol for encounter data elements reporting/records;

A.16.1.2.7 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

A.16.1.2.8 Payment policies;

A.16.1.2.9 Information on members' appeal rights;

A.16.1.2.10 Member rights and responsibilities;

A.16.1.2.11 Policies and procedures of the provider complaint system; and

A.16.1.2.12 Important phone numbers of all departments/staff a NEMT provider may need to reach at the CONTRACTOR's MCO.

A.16.1.3 The CONTRACTOR shall disseminate bulletins to NEMT providers as needed to incorporate any needed changes to the provider manual.

A.16.2 NEMT Provider Education and Training

A.16.2.1 The CONTRACTOR shall develop and implement a plan to educate NEMT providers, including initial orientation sessions and continuing education. The initial orientation shall include at minimum the topics included in the NEMT provider manual.

A.16.2.2 The CONTRACTOR shall ensure that all NEMT provider staff, including but not limited to dispatchers, supervisors, and mechanics, receive appropriate training before providing services under the Agreement and on an ongoing basis thereafter.

A.17 NEMT QUALITY ASSURANCE AND MONITORING

A.17.1 NEMT Quality Assurance Program

A.17.1.1 As part of the CONTRACTOR's QM/QI program, the CONTRACTOR shall develop and implement a quality assurance program for NEMT services. The description of the program (the NEMT Quality Assurance Plan) shall include policies and procedures outlining the objectives and scope of the program as well as activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of NEMT services.

A.17.1.2 The NEMT Quality Assurance Plan shall include at least the following:

A.17.1.2.1 The CONTRACTOR's procedures for monitoring and improving member satisfaction with NEMT services;

A.17.1.2.2 The CONTRACTOR's procedures for ensuring that all NEMT services paid for are properly approved and actually rendered, including but not limited to validation checks (see Sections A.4.6 and A.14.3) and an annual analysis matching physical health and behavioral health claims/encounters and NEMT claims/encounters;

A.17.1.2.3 The CONTRACTOR's procedures for monitoring and improving the quality of transportation provided pursuant to the Agreement, including transportation provided by fixed route; and

A.17.1.2.4 The CONTRACTOR's monitoring plan for NEMT providers, as detailed in Section A.17.3 of this Attachment.

A.17.2 Accidents and Incidents

The CONTRACTOR shall document accidents and incidents that occur while services are being delivered under the Agreement. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as a passenger being unruly or ill.

A.17.3 NEMT Provider Monitoring Plan

A.17.3.1 The CONTRACTOR shall develop and implement a plan for monitoring NEMT providers' compliance with all applicable local, state and federal law. The plan shall also monitor NEMT providers' compliance with the terms of their provider agreements and all NEMT provider-related requirements of the Agreement, including but not limited to driver requirements, vehicle requirements, member complaint resolution requirements, and the delivery of courteous, safe, timely and efficient transportation services.

A.17.3.2 Monitoring activities shall include, but are not limited to:

A.17.3.2.1 On-street observations;

A.17.3.2.2 Random audits of NEMT providers;

A.17.3.2.3 Accident and incident reporting;

A.17.3.2.4 Statistical reporting of trips;

A.17.3.2.5 Analysis of complaints;

A.17.3.2.6 Driver licensure, driving record, experience and training;

A.17.3.2.7 Enrollee safety;

A.17.3.2.8 Enrollee assistance;

A.17.3.2.9 Completion of driver trip logs;

A.17.3.2.10 Driver communication with dispatcher; and

A.17.3.2.11 Routine scheduled vehicle inspections and maintenance.

A.17.4 **NEMT Provider Corrective Action**

A.17.4.1 The CONTRACTOR shall have policies and procedures for ensuring that an appropriate corrective action is taken when a NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services that should have been furnished, or when a NEMT provider is out of compliance with federal, state, or local law.

A.17.4.2 The CONTRACTOR shall immediately remove from service any vehicle, driver, or EMT found to be out of compliance with the requirements of the Agreement, including any federal, state or local law. The vehicle, driver, or EMT may be returned to service only after the CONTRACTOR verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, shall be documented and become a part of the vehicle's and/or the person's permanent records.

A.17.4.3 As required in Section A.19.6.7 of this Attachment, the CONTRACTOR shall report on monitoring activities, monitoring findings, corrective actions taken, and improvements made.

A.17.5 **NEMT Member Satisfaction Survey**

A.17.5.1 The CONTRACTOR shall conduct a member satisfaction survey regarding NEMT services for the first six (6) months after implementation of the requirements in this Attachment or as otherwise specified by TENNCARE and annually thereafter.

A.17.5.2 The purpose of the survey is to verify the availability, appropriateness and timeliness of the trips provided and the manner in which the CONTRACTOR's staff and the NEMT provider's staff interacted with members.

A.17.5.3 The survey topics shall include, but are not limited to:

A.17.5.3.1 NEMT Call Center interaction;

A.17.5.3.2 Confirmation of a scheduled trip;

A.17.5.3.3 Driver and CONTRACTOR staff courtesy;

A.17.5.3.4 Driver assistance, when required;

A.17.5.3.5 Overall driver behavior;

A.17.5.3.6 Driver safety and operation of the vehicle;

A.17.5.3.7 Condition, comfort and convenience of the vehicle; and

A.17.5.3.8 Punctuality of service.

A.17.5.4 The format, sampling strategies and questions of the survey must be prior approved in writing by TENNCARE, and TENNCARE may specify questions that are to appear in the survey.

A.17.5.5 The CONTRACTOR shall submit reports regarding these surveys as required in Section A.19.6.8 of this Attachment.

A.17.6 **Vehicle Inspection**

A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all NEMT providers' vehicles prior to the implementation of NEMT requirements in this Attachment. Thereafter, the CONTRACTOR shall conduct a comprehensive inspection of all vehicles at least annually. The CONTRACTOR is not required to inspect fixed route vehicles, invalid vehicles, ambulances, or vehicles for NEMT providers with which the CONTRACTOR does not have a provider agreement (see Section A.13.2 of this Attachment).

A.17.6.2 The CONTRACTOR shall develop and implement policies and procedures for vehicle inspections. These policies and procedures must be prior approved in writing by TENNCARE and shall include inspection forms, inspection stickers and a list of trained inspectors, including the names of all employees or subcontractors who are authorized to inspect vehicles for the CONTRACTOR. Inspection forms shall have a checklist that includes all the applicable vehicle standards of the Agreement and of local, state and federal law. The CONTRACTOR shall test all communication equipment during all vehicle inspections.

A.17.6.3 Upon completion of a successful inspection, an inspection sticker shall be applied to the vehicle. The inspection sticker shall be placed on the outside of the passenger side rear window in the lower right corner. The sticker shall state the license plate number and vehicle

identification number of the vehicle. Records of all inspections shall be maintained by the CONTRACTOR.

A.18 NEMT SUBCONTRACTS

If the CONTRACTOR delegates any of its responsibilities regarding NEMT services, it shall comply with the subcontracting requirements in the Agreement, including prior written approval of the subcontract by TENNCARE.

A.19 NEMT REPORTING

A.19.1 NEMT Status Reports

A.19.1.1 During the initial six (6) months after implementation of NEMT services pursuant to this Attachment, and longer if requested by TENNCARE, the CONTRACTOR shall submit a weekly status report. This report shall include, but not be limited to, a NEMT narrative summary of accomplishments, identification of open and closed issues, key Call Center telephone statistics (e.g., number of calls received, number/percentage of calls placed on hold, average hold time, number/percentage of abandoned calls; average talk time; and number of staff to answer calls by time of day/day of week), key statistics on requests for transportation (e.g., number of requests by mode of transportation, number denied and approved, and mode of transportation approved); and key statistics on pick-up and delivery standards.

A.19.1.2 The CONTRACTOR shall submit a monthly status report. This report shall include, but not be limited to, summary and detail information on accomplishments, outstanding issues, NEMT Call Center statistics, NEMT Call Center activities, and statistics regarding pick-up and delivery standards.

A.19.2 Approval and Utilization Reports

A.19.2.1 Approval Report. The CONTRACTOR shall submit a quarterly approval report that includes both summary and detail information on transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by mode of transportation and category of service.

A.19.2.2 Approval and Scheduling Timeframes Report. The CONTRACTOR shall submit a quarterly report that provides information on timeframes for approving/denying and scheduling transportation.

A.19.2.3 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the number and percentage of pick-ups that were missed by a NEMT provider, pick-ups or drop-offs that were late, and drop-offs where the member missed an appointment and provides the average amount of time that the pick-ups or drop-offs were late. This information shall be provided by mode of transportation and by county.

A.19.2.4 Utilization Report. The CONTRACTOR shall submit a monthly utilization that provides both summary and detail information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation and category of service: the number of trips, number of unduplicated members, and number of miles.

A.19.3 **NEMT Call Center Reports**

A.19.3.1 The CONTRACTOR shall submit a monthly report that provides summary and detail statistics on the NEMT Call Center telephone lines/queues and includes identification of potential issues, trends, and any corrective action taken.

A.19.3.2 The CONTRACTOR shall submit a monthly report that summarizes the results of the CONTRACTOR's call monitoring and any corrective action taken.

A.19.4 **NEMT Provider Enrollment File**

The CONTRACTOR's monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE:

A.19.4.1 Driver Roster. The CONTRACTOR shall provide a driver roster for each NEMT provider that includes, at minimum: the driver's name, license number, and social security number.

A.19.4.2 Vehicle Listing. The CONTRACTOR shall provide a vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle's manufacturer, model, model year, and vehicle identification number.

A.19.5 **NEMT Claims Management Reports**

A.19.5.1 The CONTRACTOR shall submit a quarterly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.

A.19.5.2 The CONTRACTOR shall submit a quarterly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all "processed or paid" NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month in the quarter.

A.19.6 **NEMT Quality Assurance and Monitoring Reports**

A.19.6.1 Member NEMT Complaint Report. The CONTRACTOR shall submit a quarterly member complaints report (see Section 1 of the Agreement for the definition of complaint, which includes both written and verbal statements) that summarizes the number of complaints regarding NEMT by type, analyzes the information, particularly noting patterns or trends, and describes any corrective action taken to ensure quality of services.

A.19.6.2 NEMT Provider Complaint Report. The CONTRACTOR shall submit a quarterly NEMT provider complaints report that summarizes the number of verbal and written complaints by type, analyzes the information, including patterns or trends, and describes any corrective action.

A.19.6.3 NEMT Quality Assurance Plan. As part of its annual QM/QI reporting required by the Agreement, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).

A.19.6.4 NEMT Validation Checks.

A.19.6.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR, the findings, and any corrective actions.

A.19.6.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR, the findings, and any corrective actions.

A.19.6.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.

A.19.6.6 Accidents and Incidents.

A.19.6.6.1 Immediately upon becoming aware of any accident resulting in driver or passenger injury or fatality that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident report within five (5) business days of the accident and shall cooperate in any related investigation. A police report shall be included in the accident report or provided as soon as possible.

A.19.6.6.2 The CONTRACTOR shall submit a quarterly report of all accidents, moving traffic violations, and incidents.

A.19.6.7 Monitoring Plan.

A.19.6.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).

A.19.6.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.

A.19.6.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

A.20 Performance Standards

The CONTRACTOR agrees that TENNCARE may assess liquidated damages against the CONTRACTOR for failure to meet the performance standards as specified in Exhibit F of this Attachment.

Amendment Number 3 (cont.)

31. The renamed Attachment XII shall be amended by labeling the existing chart as Exhibit A , changing the ending date to March 31, 2008 and adding two new charts labeled Exhibit B and Exhibit C as follows:

EXHIBIT B
CAPITATION RATES
EFFECTIVE April 1, 2008 through June 30, 2008

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related) And Standard Spend Down	Age Under 1	$ 436.42
	Age 1 - 13	$ 81.41
	Age 14 - 20 Female	$ 183.42
	Age 14 - 20 Male	$ 93.26
	Age 21 - 44 Female	$ 311.25
	Age 21 - 44 Male	$ 184.89
	Age 45 – 64	$ 355.56
	Age 65 +	$ 378.03
Uninsured/Uninsurable	Age Under 1	$ 436.42
	Age 1 - 13	$ 61.78
	Age 14 - 19 Female	$ 101.62
	Age 14 – 19 Male	$ 76.89
Disabled	Age < 21	$ 608.81
	Age 21 +	$ 704.31
Duals/Waiver Duals	All Ages	$ 226.31
State Only & Judicials	All Ages	$ 516.06
Priority Add-On	Age < 21	$ 294.75
	Age 21 +	$ 294.75

Amendment Number 3 (cont.)

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

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

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 April 1, 2008.

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: 6/27/08

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY: _____
Eric H. Paul
Chief Executive Officer, TennCare

DATE: 6-26-08

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: 7/1/08

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
John G. Morgan
Comptroller

DATE: 7-7-08

Exhibit A
DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Attachment shall be given the meaning used in TennCare rules and regulations. However, the following terms, when used in this Attachment, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

Definitions

1. **Commercial Carrier Transport:** Transportation provided by a common carrier, including but not limited to buses (e.g., Greyhound), trains (e.g., Amtrak), airplanes, and ferries.
2. **Curb-to-Curb Service:** Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the enrollee's needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any enrollee. The driver shall remain at or near the vehicle and not enter any buildings.
3. **Door-to-Door Service:** Transportation provided to enrollees with disabilities who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver shall exit the vehicle and assist the enrollee from the door of the pick-up point, e.g., residence, accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the enrollee throughout the transport and to the door of the destination.
4. **Federal Motor Carrier Safety Administration (FMCSA): A separate administration within** the United States Department of Transportation established pursuant to the Motor Carrier Safety Improvement Act of 1999. Its primary mission is to reduce crashes, injuries, and fatalities involving large trucks and buses.
5. **Fixed Route:** Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops. Fixed route transportation includes, but is not limited to, non-commercial buses, commuter trains, and trolleys.
6. **Hand-to-Hand Service: Transportation of an enrollee** with disabilities from an individual at the pick-up point to a provider staff member, family member or other responsible party at the destination.
7. **Hospital Discharge:** Notification by a hospital that an enrollee is ready for discharge. A hospital discharge shall be considered an urgent trip.

8. **HRAs:** Human Resource Agencies. These agencies are the delivery system for human services, including transportation to rural residents, throughout the State of **Tennessee. The nine HRAs are: Delta HRA, East Tennessee HRA, First Tennessee HRA,** Mid-Cumberland HRA, Northwest HRA, South Central Development District, South West HRA, Upper Cumberland HRA, and South East HRA.

9. **No-Show:** A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member is not present five (5) minutes after the scheduled pick-up time.

10. **Private Automobile:** An enrollee's personal vehicle or the personal vehicle of a family member or friend, to which the enrollee has access. Private automobile is not a covered NEMT service.

11. **Single Trip:** Transport to and/or from a single TennCare covered service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.

12. **Standing Order:** Transport to and/or from multiple recurring medical appointments for TennCare covered services for the same enrollee with the same provider for the same treatment or condition (can be one (1) or multiple trip legs).

13. **TennCare Covered Services: The health care services available to TennCare enrollees, as defined in TennCare** rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, and dental services provided through managed care companies (MCCs), as well as institutional services and alternatives to institutional services (home and community based waiver services) provided by entities that are not MCCs. **TennCare covered services includes TENNderCare services.**

14. **Tennessee Division of Mental Retardation Services (DMRS):** The state agency responsible for providing services and supports to Tennesseans with mental retardation. DMRS is a division of the Tennessee Department of Finance and Administration.

15. **Trip Leg: One-way transport from a pick-up** point to a destination. A trip generally has at least two (2) trip legs.

16. **Urgent Trip:** Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital discharge shall be an urgent trip.

Exhibit B
TRIP MANIFESTS

The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip for each enrollee, including but not limited to:

1. Number assigned by the CONTRACTOR for approved trip;
2. NEMT provider name;
3. The mode of transportation;
4. MCO/BHO name;
5. Enrollee's name;
6. Enrollee's age;
7. Enrollee's sex;
8. Trip date;
9. Number of legs for the trip (e.g., one-way, round trip, or multiple legs);
10. Origin of trip/place of pick-up (e.g., residence)
11. Time of pick-up for the time zone applicable to the pick-up location;
12. Address of the pick-up, including street address, city, county, state, and zip code;
13. Enrollee's phone number(s);
14. Number of riders;
15. Time of appointment for the time zone applicable to the appointment location;
16. Provider name;
17. Address of the provider, including street address, city, county, state, and zip code;
18. Provider's phone number(s);
19. Return trip times for the applicable time zone(s) and addresses, if applicable;
20. Any additional stops (e.g., pharmacy);
21. Any special needs of the enrollee;
22. Any special instructions to the driver, e.g., door-to-door or hand-to-hand service;
23. Whether enrollee has third party coverage, including Medicare; and
24. Notes.

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit C
VEHICLE REQUIREMENTS

All vehicles, except for fixed route vehicles and ambulances, shall meet the following requirements:

1. The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity.
2. All vehicles shall have adequately functioning heating and air-conditioning systems.
3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. All vehicles shall have an easily visible interior sign that states: "ALL PASSENGERS SHALL USE SEAT BELTS". Seat belts shall be stored off the floor when not in use.
4. Each vehicle shall use child safety seats in accordance with state law.
5. All vehicles shall have at least two (2) seat belt extensions.
6. For use in emergency situations, each vehicle shall be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.
7. All vehicles shall have functioning interior light(s) within the passenger compartment.
8. All vehicles shall have an accurate, operating speedometer and odometer.
9. All vehicles shall have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.
10. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.
11. The exterior of all vehicles shall be clean and free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicles.
12. The interior of all vehicles shall be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.
13. All vehicles shall be smooth riding, so as not to create passenger discomfort.
14. All vehicles shall have the NEMT provider's business name and telephone number decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.
15. To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that TennCare enrollees are being transported. The name of the NEMT provider's business may not imply that TennCare enrollees are being transported.
16. The vehicle license number and the CONTRACTOR's toll-free phone number shall be prominently displayed on the interior of each vehicle. This information and the complaint procedures shall be clearly visible and available in written format (at a minimum, in English and Spanish) in each vehicle for distribution to enrollees upon request.
17. The vehicle shall have a current inspection sticker issued by the CONTRACTOR on the outside of the passenger side rear window in the lower right corner.
18. Smoking shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: "NO SMOKING".

Amendment Number 3 (cont.)

19. All vehicles shall carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.
20. All vehicles shall be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves, and sterile eyewash.
21. Each vehicle shall contain a current map of the applicable geographic area with sufficient detail to locate enrollee and provider addresses.
22. Each vehicle shall be equipped with a regulation size Class B chemical type fire extinguisher. The fire extinguisher shall have a visible, current (up-to-date) inspection tag or sticker showing an inspection of the fire extinguisher by the appropriate authority within the past twelve (12) months. The extinguisher shall be mounted in a bracket located in the driver's compartment and be readily accessible to the driver and passenger(s).
23. Each vehicle shall be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
24. Each vehicle shall be equipped with emergency triangles.
25. Each vehicle that is required to stop at all railroad crossings shall have a railroad crossing decal that says that the vehicle stops at all railroad crossings.
26. Each vehicle shall have a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute.

Exhibit D
DRIVER REQUIREMENTS

The requirements listed below shall apply to all drivers of vehicles other than fixed route vehicles and ambulances.

1. All drivers shall be courteous, patient, and helpful to all passengers.
2. All drivers shall be neat and clean in appearance.
3. No driver shall use alcohol, narcotics, illegal drugs or prescription medications that impair the ability to perform while on duty. No driver shall abuse alcohol or prescription medications or use illegal drugs at any time.
4. All drivers shall wear and have visible an identification badge that is easily readable and identifies the driver and the NEMT provider.
5. No driver shall smoke or eat while in the vehicle, while assisting an enrollee, or in the presence of any enrollee.
6. Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or the CONTRACTOR.
7. Drivers shall exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle.
8. The driver shall provide an appropriate level of assistance to an enrollee when requested or when necessitated by the enrollee's mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.
9. The driver shall assist enrollees in the process of being seated including the fastening of seat belts, securing children in properly-installed child safety seats, and properly securing passengers in wheelchairs.
10. The driver shall confirm, prior to departure, that all seat belts are fastened properly, and that all passengers, including passengers in wheelchairs, are safely and properly secured.
11. Upon arrival at the destination, the driver shall park the vehicle so that the enrollee does not have to cross streets to reach the entrance of the destination.
12. Drivers shall visually confirm that the enrollee is inside the destination.
13. The driver shall not leave an enrollee unattended at any time.
14. If an enrollee or other passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.

Exhibit E
DRIVER LOGS

The CONTRACTOR shall require that the NEMT providers' drivers maintain daily transportation logs containing, at a minimum, the information listed below. Fixed route transportation is excluded from this requirement.

1. Date of service;
2. Driver's name;
3. Driver's signature;
4. Name of escort or accompanying adult (for enrollees under age eighteen (18) and relationship to enrollee (if applicable);
5. Vehicle Identification Number (VIN);
6. Enrollee's name;
7. The NEMT provider's name;
8. Number assigned by the CONTRACTOR for the approved trip;
9. Mode of transportation approved;
10. Actual start time (from the base station) for the time zone applicable to the starting location;
11. Scheduled pick-up time for the time zone applicable to the pick-up location;
12. Actual pick-up location and time for the time zone applicable to the pick-up location;
13. Actual departure time from pick-up location for the time zone applicable to the pick-up location;
14. Actual destination and time for the time zone applicable to the destination;
15. Actual number of wheelchairs, escorts, and accompanying adults (for enrollees under age eighteen (18));
16. Odometer readings at each point of pick-up and of drop-off; and
17. Notes, if applicable. At a minimum, the log shall show notes in the case of cancellations, incomplete requests, "no-shows", accident and incident.

For ambulance, the log shall also contain, at a minimum:

1. Patient assessment by ambulance personnel and a chronological narrative of care/service rendered by ambulance personnel;
2. Itemized list of specialized services and/or supplies; and
3. Type of vehicle used for transport (class or service category).

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Amendment Number 3 (cont.)

Exhibit F
PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
1	Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)	$500 per deficiency
2	Comply with the approval and scheduling timeframes (see Section A.5.1.3 of this Attachment)	$1,000 per deficiency
3	Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)	$500 per deficiency
4	Comply with pick-up and delivery standards (see Section A.6 of this Attachment)	$100 per deficiency
5	Comply with vehicle standards (see Section A.7 of this Attachment)	$1,500 per calendar day per vehicle that is not in compliance with ADA requirements $1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement $2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants $500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience $100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)	$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards
7	No more than 1% of calls to the NEMT Call Center are blocked (see Section A.9 of this Attachment)	For the first deficiency: $5,000 for each full percentage point above 1% per month per line/queue For the second deficiency: $10,000 for each full percentage point above 1% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point above 1% per month per line/queue

Amendment Number 3 (cont.)

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
8	90% of all calls to the NEMT Call Center are answered by a live voice within thirty (30) seconds (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each full percentage point below 90% per month per line/queue For the second deficiency: $10,000 for each full percentage point below 90% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point below 90% per month per line/queue
9	Less than 5% of calls to the NEMT Call Center are abandoned (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each full percentage point above 5% per month per line/queue For the second deficiency: $10,000 for each full percentage point above 5% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point above 5% per month per line/queue
10	Average hold time for calls to the NEMT Call Center is no more than 3 minutes (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each 10 seconds over 3 minutes per month per line/queue For the second deficiency: $10,000 for each 10 seconds over 3 minutes per month per line/queue For the third and subsequent deficiencies: $15,000 for each 10 seconds over 3 minutes per month per line/queue
11	Process 90% of clean NEMT claims within thirty (30) calendar days of the receipt of the claim and process 99.5% of claims within sixty (60) calendar of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)		$10,000 for each month determined not to be in compliance
12	97% of NEMT claims are paid accurately upon initial submission (see Section A.15.5 of this Attachment)		$5,000 for each full percentage point accuracy is below 97% for each quarter

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
318.66-051	FA-07-16937-02
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 01

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	June 30, 2010	subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009					$ -
2010					$ -
					$ -
					$ -
TOTAL	$ 317,084,646.00	$ 557,269,816.00	$ -	$ -	**$ 874,354,462.00**

OCR RELEASED
JUN 29 2007
agina
TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009		
2010		
		$ -
TOTAL	$ 874,354,462.00	$ -
End Date	June 30, 2010	

State Agency Fiscal Contact & Telephone #

Scott Pierce 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)

RECEIVED
JUN 22 2007
PROCUREMENT OFFICE
DEPARTMENT OF FINANCE & ADMINISTRATION

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

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government (eg,ID,GG,GU) [ ] Other

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

OCR
JUN 22 2007
RECEIVED

CONTRACT SUMMARY SHEET

021408

318.66-051	FA-07-16937-02
Department of Finance and Administration	Bureau of TennCare
UnitedHealthCare Plan of the River Valley, Inc.	C- or X V- 363379945 01

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

August 15, 2006	June 30, 2010	subrecipient	93.778 Dept. of Health and Human Services/Title XIX

Contractor is on STARS

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

318.66	4M9	134	11		

2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009					$ -
2010					$ -
					$ -
					$ -
	$ 317,084,646.00	$ 557,269,816.00	$ -	$ -	$ 874,354,462.00

Scott Pierce 687-6415

2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009		
2010		
		$ -
	$ 874,354,462.00	$ -
	June 30, 2010	

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

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

(General)**AMENDMENT NUMBER 2**

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

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" or "State" 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 adding a definition for "Intervention".

   Intervention - An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

2. Section 2.4.9.5 shall be deleted and replaced as follows:

   2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO

agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

3. Section 2.7.2.11.1 shall be amended by changing the evaluation time frame from "60 to 90 days" to "30 to 60 days".

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

4. Section 2.7.5.2.2 shall be amended by adding a new Section 2.7.5.2.2.1.

2.7.5.2.2.1 The CONTRACTOR shall have the ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or non-English speaking. At least one of the 6 outreach attempts identified above must advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

5. Section 2.7.5.2.4 shall be amended by adding the word "written" in the first sentence before the word "process".

2.7.5.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up must include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

6. Section 2.7.7.3.1.3 shall be amended by adding additional text to the end of the existing text.

2.7.7.3.1.3 The member or her authorized representative, if any, has signed and dated a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form which is available on TENNCARE's web site, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary. Refer to "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form and instructions for additional guidance and exceptions.

7. Section 2.8.2.1 shall be deleted and replaced as follows:

2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

2.8.2.1.1 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

Amendment Number 2 (cont.)

Amendment Number 2 (cont.)

8. Section 2.8.7 shall be deleted and replaced as follows:

2.8.7 **Program Evaluation (Satisfaction and Effectiveness)**

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

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

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

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

2.8.7.2.2 The rate of emergency department utilization and inpatient hospitalization;

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

2.8.7.2.4 Appropriate HEDIS measures;

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

2.8.7.2.6 Cost savings;

2.8.7.2.7 Member adherence to treatment plans; and

2.8.7.2.8 Provider adherence to the guidelines.

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

9. Section 2.9.4.1.5 shall be deleted and replaced as follows:

2.9.4.1.5 Program Evaluation.

10. Section 2.9.4.2 shall be deleted and replaced as follows:

2.9.4.2. The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:

2.9.4.2..1 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program, whichever the CONTRACTOR determines is more appropriate. and

2.9.4.2..2 Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions.

Amendment Number 2 (cont.)

11. Section 2.9.11.5 shall be amended by adding new Sections 2.9.11.5.1 through 2.9.11.5.2.3.

2.9.11.5 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.11.5.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers and the Department of Health's Project Teach staff to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment.

2.9.11.5.2 The CONTRACTOR must designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the MCO must:

2.9.11.5.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service authorization and assist, if necessary, in making an appointment to have the child evaluated by the child's PCP or another in-network provider in accordance with the time frames specified in the TennCare Waiver Terms and Conditions for access to care.

2.9.11.5.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.11.5.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery).

12. Section 2.11.1.6 shall be amended by adding new text and shall read as follows:

2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

13. Section 2.11.2.1 shall be amended by deleting the word "identified" and replacing it with the word "assigned".

2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member.

14. Section 2.17.5 shall be deleted and replaced as follows:

2.17.5 **Quarterly Member Newsletter**

2.17.5.1 **General Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 **Teen/Adolescent Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

2.17.5.2.1 The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and

2.17.5.2.1.1.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

2.17.5.2.1.1.3 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.3.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.5.3.3 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;

2.17.5.3.4 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;

2.17.5.3.5 Information about appropriate prescription drug usage;

2.17.5.3.6 TENNCARE and MCO member services toll-free telephone numbers, including the

TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and

2.17.53.7 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."

2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 4-8 of this Agreement.

15. Section 2.18.4 shall be amended by adding a new Section 2.18.4.6, renumbering the remaining Sections accordingly and updating all references thereto.

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

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

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

2.18.4.3 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m. Central Time, Monday through Friday, except State of Tennessee holidays.

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

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

2.18.4.6 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR must have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who

are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 Nurse Triage line described in Section 2-18.1.5 of this Agreement for this purpose or may use another line the CONTRACTOR designates. The CONTRACTOR shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting in accordance with Section 2.30.12.1.3.

2.18.4.7 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.8 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

16. Section 2.23.4.3.7 shall be amended by adding "(including NPI number and Medicaid Number)" in the third sentence.

2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio reports and supply the reconciliation to TENNCARE with each of the Medical Loss Ratio report submissions as specified in Section 2.30.14.2.1.

17. Section 2.30.5.2 shall be deleted and replaced as follows:

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. The report shall be submitted in a format prescribed by TENNCARE.

18. Section 2.30.6 shall be deleted and replaced as follows:

2.30.6 **Service Coordination Reports**

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 By August 15, 2007, the CONTRACTOR shall submit an annual *Case Management Services Report* to TENNCARE describing the CONTRACTOR's case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the CONTRACTOR shall submit a report outlining any changes to the case management program, along with justification for such changes. These reports should only contain case management activity.

2.30.6.1.2 The CONTRACTOR shall submit a quarterly MCO Case Management Update Report that includes a brief narrative description of the MCO case management program (see Section 2.9.4); the total number of members enrolled in the MCO case management program; number of members enrolled and disenrolled in the program during the quarter; member selection criteria; the number of members who declined case management services; a description of services provided during the quarter and an evaluation of the impact of the MCO case management program during the quarter. The CONTRACTOR shall submit these reports in a format prescribed by TENNCARE. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management

19. Section 2.30.7.3 shall be deleted and replaced as follows:

2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. This report shall be submitted using the format provided in Attachment IX, Exhibit F. (See Section 2.11.2.)

20. Section 2.30.7 shall be amended by adding a new 2.30.7.7.

2.30.7.7 The CONTRACTOR shall submit a monthly *Institutions for Mental Diseases (IMD) Out-of-State Report* on the use of IMDs utilized outside of the state of Tennessee. The report shall be submitted by the 5th of each month for the previous month and in a format prescribed by TENNCARE.

21. Section 2.30.10.3 shall be deleted and replaced as follows:

2.30.10.3 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be submitted using the format provided in Attachment IX, Exhibit J. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

22. Section 2.30.10.5 shall be amended by adding ", and other identifying information" in the last sentence.

2.30.10.5 The CONTRACTOR shall identify and report the number of members who incurred claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.

23. 2.30.10 shall be amended by adding a new 2.30.10.8 and 2.30.10.9 which shall read as follows:

2.30.10.8 The CONTRACTOR shall submit a monthly *Emergency Room Visit Report* by PCP that includes the following information: Provider Name, Provider Medicaid I.D. Number, NPI Number, Provider Specialty, Number of Members assigned, and Number of ER Visits. This report shall include a rolling twelve (12) months which shall be refreshed on a monthly basis and submitted with a thirty (30) day lag. Each monthly report is due to TENNCARE by the 5th calendar day of the following month.

2.30.10.9 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* to TENNCARE no later than February 28th and August 31st each year identifying members who exceeded the defined threshold for ED usage and specifying the interventions initiated for each member.

24. Section 2.30.11.1 shall be amended by adding a new Section 2.30.11.1.1.

2.30.11.1.1 As a part of the annual QM/QI reporting requirements, the CONTRACTOR must submit the names of the clinical practice guidelines (ADA, AMA, etc.) along with a report on the results of performance measures utilized for each.

25. Section 2.30.11.5 shall be amended by adding "(the final bound copy from NCQA)".

2.30.11.5 The CONTRACTOR shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA

26. Section 2.30.12 shall be deleted and replaced as follows:

2.30.12 **Customer Service/Provider Service Reports**

2.30.12.1 Member Services/UM/ED Phone Line Reports

2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services and UM Phone Line Report.* The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

2.30.12.1.2 The CONTRACTOR shall submit a *24/7 ED Assistance Line Report* no later than August 1, 2007, providing the telephone number that will be used for hospitals requiring scheduling assistance for and describing the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line.

2.30.12.1.3 The CONTRACTOR shall submit a quarterly *24/7 Nurse Triage Line Report* that lists the total

calls received by the 24/7 Nurse Triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2.18.4.6 of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-30.12.1.4 of this Agreement.

2.30.12.1.4 The CONTRACTOR submit shall submit a quarterly *ED Assistance Tracking Report* that provides the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report will include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the Nurse Triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2-30.12.1.3.

2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter. The CONTRACTOR shall submit the report in a format to be prescribed by TENNCARE.

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement (see Section 2.18.7.2).

2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone. The data shall be reported by month in a format to be specified by TENNCARE.

27. Section 2.30.19 shall be amended by adding the word "Privacy".

2.30.19 HIPAA Reports

The CONTRACTOR shall submit a Privacy/Security Incident Report in a format to be prescribed by TENNCARE. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

28. The Liquidated Damages Chart in Section 4.20.2.2.7 shall be amended by adding a new C.5 which shall read as follows:

C.5	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 2.4.9.5		$1000.00 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of $5,000 per occurrence

29. Section 4.30 shall be deleted and replaced with LEFT BLANK INTENTIONALLY.

4.30 LEFT BLANK INTENTIONALLY

30. ATTACHMENT VIII shall be amended to include updates of reporting requirements as amended in Amendments 1 and 2 to the Middle TN MCO CRA.

31. ATTACHMENT IX, Exhibit F shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

Amendment Number 2 (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, 2007 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: MD Goetz Jr /SG
M. D. Goetz, Jr.
Commissioner

DATE: 6/19/07

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY:
Eric H. Paul
Chief Executive Officer, TennCare

DATE: 6-12-07

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M.D. Goetz Jr /KS
M. D. Goetz, Jr.
Commissioner

DATE: 6/26/07

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan /CM
John G. Morgan
Comptroller

DATE: 6-28-07

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
318.66-051	FA-07-16937-01
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 00

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
August 15, 2006	June 30, 2010`	subrecipient	93.778 Dept. of Health and 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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009					$ -
2010					$ -
					$ -
					$ -
TOTAL:	$ 317,084,646.00	$ 557,269,816.00	$ -	$ -	**$ 874,354,462.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$174,870,888.00	
2008	$ 699,483,574.00	
2009		
2010		
		$ -
TOTAL:	$ 874,354,462.00	$ -
End Date	June 30, 2010	

State Agency Fiscal Contact & Telephone #

Scott Pierce 507-6415

State Agency Budget Officer Approval

Funding Certification (certification required by T.C.A. §9-4-5118 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 only for base contracts with contract # prefix 'FA' or 'GR')

[ ] African American [ ] Person w/ Disability [ ] Hispanic [ ] Small Business [x] NOT disadvantaged

[ ] Asian [ ] Female [ ] Native American [ ] OTHER minority/disadvantaged—

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method

[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government (e.g. D, CG, GU) [ ] Other

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

RECEIVED
2006 DEC 21 AM 10:30
COMPTROLLER OF THE TREASURY
MANAGEMENT SERVICES

AMENDMENT NUMBER 1

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

CONTRACT NUMBER: FA-07-16937-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" or "State" 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 2-13.2 shall be deleted and replaced in its entirety.

2.13.2 Hospice

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

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

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

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

2. Section 2.6.1.3 shall be deleted and replaced in its entirety.

2.6.1.3 Soft Limits/Service Thresholds for Certain Physical Health Services

2.6.1.3.1 TENNCARE has established thresholds that apply to certain covered physical health services for non-institutionalized Medicaid adults. The CONTRACTOR shall track, in a manner prescribed by TENNCARE, and report on accumulated benefit information for each service that has a threshold. Depending on the service, once a member reaches a threshold, the CONTRACTOR shall evaluate and enroll the member in MCO case management or a disease management program as appropriate.

2.6.1.3.2 The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program, whichever is more appropriate

3. Section 2.20.3.1 shall be amended by adding new text to the end of the existing text so that the amended Section 2.20.3.1 shall read as follows:

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.

4. Section 2.23.4.3.1 shall be amended by adding additional text to the end of the existing text so that the amended Section 2.23.4.3.1 shall read as follows:

2.23.4.3.1 Within two (2) business days of the end of a payment cycle the CONTRACTOR shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

5. Section 2.30.1.3 shall be amended by adding a due date for Semi-Annual Reports which shall read as follows:

Semi-Annual Reports		January 31 and July 31.

6. Section 2.30.3 shall be deleted and labeled "LEFT BLANK INTENTIONALLY".

2.30.3 **LEFT BLANK INTENTIONALLY**

7. Section 2.30.10 shall be amended by adding a new Section 2.30.10.2 and renumbering the existing sections accordingly.

2.30.10.2 The CONTRACTOR shall submit a quarterly *PCP Visits Per Member Per Year Report* in the format prescribed by TENNCARE. The number of PCP visits per member during the reporting quarter shall be projected to reflect a twelve (12) month period.

8. Section 3.1.2 shall be amended by adding new text so that the amended Section 3.1.2 shall read as follows:

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1 and any incentive payments (if applicable) are payment in full for all services provided pursuant to this Agreement. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at Tennessee Code Annotated *§ 56-32-201* et seq. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at Tennessee Code Annotated § 56-51-101 et seq. or any subsequent amendments thereto. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

9. Section 4.14 shall be deleted and replaced in its entirety.

4.14 NOTIFICATION OF LEGAL ACTION AGAINST THE CONTRACTOR

The CONTRACTOR shall give TENNCARE and TDCI immediate notification in writing by certified mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the CONTRACTOR or an affiliate of the CONTRACTOR (including but not limited to a parent company), that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The CONTRACTOR shall also provide similar notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Agreement. It is the intent of this provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR'S financial viability and/or program operations or integrity.

10. Section 4 shall be amended by adding a new Section 4.34 and renumbering the remaining items in Section 4 accordingly.

4.34 PROHIBITION OF ILLEGAL IMMIGRANTS

4.34.1 The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

4.34.2 The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment X, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.

4.34.3 Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

4.34.4. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

4.34.5. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.

4.34.6. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

11. Attachment IX, Exhibit J.3 shall be amended by adding MRI, CT Scan and PET Scan's per 1000 and shall be attached to the end of this Amendment.

Amendment Number 1 (cont.)

12. The existing Attachment X shall be renumbered as Attachment XI and all references thereto shall be amended accordingly. A new Attachment X shall be added and shall read as follows:

ATTACHMENT X

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

SIGNATURE & DATE:

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

ATTACHMENT IX, EXHIBIT J.3

[MCO NAME]
Physical Health Outpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Outpatient										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Surgery										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
ER-Emergency										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
ER Non-Emergency										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Diagnostic										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
MRI Visits per 1,000										
CT Scans Visits per 1,000										
PET Scans Visits per 1,000										
Other Services [MCO to id what is here]										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										

Amendment Number 1 (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 January 1, 2007 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: MD Goetz Jr /SCP
M. D. Goetz, Jr.
Commissioner

DATE: 12/19/06

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY:
Eric H. Paul
Chief Executive Officer, TennCare

DATE: 12-14-06

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz Jr /CS
M. D. Goetz, Jr.
Commissioner

DATE: 12/20/07

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 12/27/06

CONTRACT SUMMARY SHEET

021406

RFS #	Contract #
318.66-051	FA-07-16937-00
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
UnitedHealthCare Plan of the River Valley, Inc.	[ ] C- or [X] V- 363379945 00

Service Description

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

Contract BEGIN Date	Contract END Date	Subrecipient or Vendor?	CFDA #
15-Aug-06	June 30, 2010	subrecipient	93.778

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	4M9	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$ 63,416,928.00	$ 111,453,960.00			$ 174,870,888.00
2008	$ 253,667,718.00	$ 445,815,856.00			$ 699,483,574.00
2009					$ -
2010					$ -
					$ -
					$ -
TOTAL:	$ 317,084,646.00	$ 557,269,816.00	$ -	$ -	$ 874,354,462.00

OCR RELEASED
SEP 07 2006
TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
TOTAL:	$ -	$ -
End Date		

State Agency Fiscal Contact & Telephone #

Scott Pierce 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)

RECEIVED
2006 AUG 23 PM 3:55
FINANCE & ADMIN.
FISCAL PROCEDURES

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

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

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

[X] RFP [ ] Competitive Negotiation [ ] Alternative Competitive Method
[ ] Non-Competitive Negotiation [ ] Negotiation w/ Government(eg,ID,GG,GU) [ ] Other

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

OCR
AUG 17 2006
RECEIVED

CONTRACTOR RISK AGRE EMENT BETWEEN

THE STATE OF TENNESSEE,
d.b.a. TENNCARE

AND

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

CONTRACT NUMBER: FA_____

August 15, 2006

TABLE OF CONTENTS

SECTION 1 - DEFINITIONS, ACRONYMS, AND ABBREVIATIONS **2**

SECTION 2 – PROGRAM REQUIREMENTS **16**

2.1 REQUIREMENTS PRIOR TO OPERATIONS 16
2.1.1 **Licensure** 16
2.1.2 **Readiness Review** 16
2.2 GENERAL REQUIREMENTS 17
2.3 ELIGIBILITY 17
2.3.1 **Overview** 17
2.3.2 **Eligibility Categories** 17
2.3.3 **TennCare Applications** 18
2.3.4 **Eligibility Determination and Determination of Cost Sharing** 18
2.3.5 **Eligibility for Enrollment in an MCO** 18
2.4 ENROLLMENT 18
2.4.1 **General** 18
2.4.2 **Authorized Service Area** 18
2.4.3 **Maximum Enrollment** 18
2.4.4 **MCO Selection and Assignment** 19
2.4.5 **Effective Date of Enrollment** 21
2.4.6 **Eligibility and Enrollment Data** 22
2.4.7 **Enrollment Period** 23
2.4.8 **Transfers from Other MCOs** 24
2.4.9 **Enrollment of Newborns** 24
2.4.10 **Information Requirements Upon Enrollment** 26
2.5 DISENROLLMENT FROM AN MCO 26
2.5.1 **General** 26
2.5.2 **Acceptable Reasons for Disenrollment from an MCO** 26
2.5.3 **Unacceptable Reasons for Disenrollment from an MCO** 26
2.5.4 **Informing TENNCARE of Potential Ineligibility** 27
2.5.5 **Effective Date of Disenrollment** 27
2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS 27
2.6.1 **CONTRACTOR Covered Benefits** 27
2.6.2 **TennCare Benefits Provided by TENNCARE** 34
2.6.3 **Medical Necessity Determination** 34
2.6.4 **Second Opinions** 35
2.6.5 **Use of Cost Effective Alternative Services** 35
2.6.6 **Additional Services and Use of Incentives** 35
2.6.7 **Cost Sharing for Services** 35
2.7 SPECIALIZED SERVICES 37
2.7.1 **Emergency Services** 37
2.7.2 **Behavioral Health Services** 38
2.7.3 **Health Education and Outreach** 43
2.7.4 **Preventive Services** 44
2.7.5 **TENNderCare** 45
2.7.6 **Advance Directives** 57
2.7.7 **Sterilizations, Hysterectomies and Abortions** 57
2.8 DISEASE MANAGEMENT 59
2.8.1 **General** 59
2.8.2 **Member Identification Strategies** 60
2.8.3 **Stratification** 61
2.8.4 **Program Content** 61
2.8.5 **Informing and Educating Members** 61
2.8.6 **Informing and Educating Providers** 61
2.8.7 **Program Evaluation** 62

2.8.8 **Obesity Disease Management** 62
2.9 SERVICE COORDINATION 62
2.9.1 **General** 62
2.9.2 **Transition of New Members** 63
2.9.3 **Transition of Care** 64
2.9.4 **MCO Case Management** 65
2.9.5 **Coordination and Collaboration Between Physical Health and Behavioral Health** 66
2.9.6 **Coordination and Collaboration Among Behavioral Health Providers** 68
2.9.7 **Coordination of Pharmacy Services** 69
2.9.8 **Coordination of Dental Benefits** 70
2.9.9 **Coordination with Medicare** 75
2.9.10 **Institutional Services and Alternatives to Institutional Services** 75
2.9.11 **Inter-Agency Coordination** 76
2.10 SERVICES NOT COVERED 76
2.11 PROVIDER NETWORK 77
2.11.1 **General Provisions** 77
2.11.2 **Primary Care Providers (PCPs)** 79
2.11.3 **Specialty Service Providers** 80
2.11.4 **Special Conditions for Prenatal Care Providers** 82
2.11.5 **Special Conditions for Behavioral Health Services** 83
2.11.6 **Safety Net Providers** 83
2.11.7 **Credentialing and Other Certification** 84
2.11.8 **Network Notice Requirements** 85
2.12 PROVIDER AGREEMENTS 87
2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS 94
2.13.1 **General** 94
2.13.2 **Hospice** 94
2.13.3 **Behavioral Health Crisis Service Teams** 95
2.13.4 **Local Health Departments** 95
2.13.5 **Physician Incentive Plan (PIP)** 95
2.13.6 **Emergency Services Obtained from Non-Contract Providers** 96
2.13.7 **Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown** 97
2.13.8 **Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown** 97
2.13.9 **Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider** 97
2.13.10 **Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR** 98
2.13.11 **Covered Services Ordered by Medicare Providers for Dual Eligibles** 98
2.13.12 **Transition of New Members** 98
2.13.13 **Transition of Care** 98
2.13.14 **Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR** 98
2.13.15 **1099 Preparation** 99
2.14 UTILIZATION MANAGEMENT (UM) 99
2.14.1 **General** 99
2.14.2 **Prior Authorization for Covered Services** 102
2.14.3 **Referrals** 103
2.14.4 **Exceptions to Prior Authorization and/or Referrals** 103
2.14.5 **PCP Profiling** 104
2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT 105
2.15.1 **Quality Management/Quality Improvement (QM/QI) Program** 105
2.15.2 **QM/QI Committee** 106
2.15.3 **Performance Improvement Projects (PIPs)** 106
2.15.4 **Performance Indicators** 107
2.15.5 **Clinical Practice Guidelines** 107

2.15.6 **NCQA Accreditation** 108
2.15.7 **HEDIS and CAHPS** 109
2.16 MARKETING 110
2.17 MEMBER MATERIALS 110
2.17.1 **Prior Approval Process for All Member Materials** 110
2.17.2 **Written Material Guidelines** 111
2.17.3 **Distribution of Member Materials** 112
2.17.4 **Member Handbooks** 112
2.17.5 **Quarterly Member Newsletter** 116
2.17.6 **Identification Card** 117
2.17.7 **Provider Directory** 117
2.17.8 **Additional Information Available Upon Request** 118
2.18 CUSTOMER SERVICE 118
2.18.1 **Member Services Toll-Free Phone Line** 118
2.18.2 **Interpreter and Translation Services** 119
2.18.3 **Cultural Competency** 120
2.18.4 **Provider Services and Utilization Management Toll-Free Telephone Line** 120
2.18.5 **Provider Handbook** 121
2.18.6 **Provider Education and Training** 121
2.18.7 **Provider Relations** 122
2.18.8 **Provider Complaint System** 122
2.18.9 **Member Involvement with Behavioral Health Services** 122
2.19 COMPLAINTS AND APPEALS 123
2.19.1 **General** 123
2.19.2 **Appeals** 124
2.20 FRAUD AND ABUSE 126
2.20.1 **General** 126
2.20.2 **Reporting and Investigating Suspected Fraud and Abuse** 126
2.20.3 **Compliance Plan** 127
2.21 FINANCIAL MANAGEMENT 129
2.21.1 **Capitation Payments** 129
2.21.2 **Savings/Loss** 129
2.21.3 **Interest** 129
2.21.4 **Third Party Liability Resources** 129
2.21.5 **Solvency Requirements** 131
2.21.6 **Accounting Requirements** 133
2.21.7 **Insurance** 133
2.21.8 **Ownership and Financial Disclosure** 134
2.21.9 **Internal Audit Function** 135
2.21.10 **Audit of Business Transactions** 136
2.22 CLAIMS MANAGEMENT 136
2.22.1 **General** 136
2.22.2 **Claims Management System Capabilities** 136
2.22.3 **Paper Based Claims Formats** 137
2.22.4 **Prompt Payment** 137
2.22.5 **Claims Dispute Management** 138
2.22.6 **Claims Payment Accuracy – Minimum Audit Procedures** 138
2.22.7 **Claims Processing Methodology Requirements** 140
2.22.8 **Explanation of Benefits (EOBs) and Related Functions** 141
2.22.9 **Remittance Advices and Related Functions** 141
2.22.10 **Processing of Payment Errors** 142
2.22.11 **Notification to Providers** 142
2.22.12 **Payment Cycle** 142
2.22.13 **Excluded Providers** 142
2.23 INFORMATION SYSTEMS 142
2.23.1 **General Provisions** 142

2.23.2 **Data and Document Management Requirements** 143
2.23.3 **System and Data Integration Requirements** 145
2.23.4 **Encounter Data Provision Requirements (Encounter Submission and Processing)** 146
2.23.5 **Eligibility and Enrollment Data Exchange Requirements** 148
2.23.6 **System and Information Security and Access Management Requirements** 149
2.23.7 **Systems Availability, Performance and Problem Management Requirements** 150
2.23.8 **System User and Technical Support Requirements** 152
2.23.9 **System Testing and Change Management Requirements** 153
2.23.10 **Information Systems Documentation Requirements** 154
2.23.11 **Reporting Requirements (Specific to Information Management and Systems Functions and Capabilities)** 154
2.23.12 **Other Requirements** 155
2.23.13 **Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems** 155
2.24 ADMINISTRATIVE REQUIREMENTS 156
2.24.1 **General Responsibilities** 156
2.24.2 **Behavioral Health Advisory Committee** 156
2.24.3 **Performance Standards** 157
2.24.4 **Medical Records Requirements** 157
2.25 MONITORING 158
2.25.1 **General** 158
2.25.2 **Facility Inspection** 159
2.25.3 **Inspection of Work Performed** 159
2.25.4 **Approval Process** 159
2.25.5 **Availability of Records** 159
2.25.6 **Audit Requirements** 161
2.25.7 **Independent Review of the CONTRACTOR** 161
2.25.8 **Accessibility for Monitoring** 161
2.25.9 **Corrective Action Requirements** 162
2.26 SUBCONTRACTS 162
2.26.1 **Subcontract Relationships and Delegation** 162
2.26.2 **Legal Responsibility** 162
2.26.3 **Prior Approval** 163
2.26.4 **Subcontracts for Behavioral Health Services** 163
2.26.5 **Standards** 163
2.26.6 **Quality of Care** 163
2.26.7 **Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions** 163
2.26.8 **Children in State Custody** 163
2.26.9 **Assignability** 163
2.26.10 **Claims Processing** 164
2.26.11 **HIPAA Requirements** 164
2.26.12 **Compensation for Utilization Management Activities** 164
2.26.13 **Notice of Subcontractor Termination** 164
2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) 164
2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS 168
2.29 PERSONNEL REQUIREMENTS 169
2.29.1 **Staffing Requirements** 169
2.29.2 **Licensure** 172
2.29.3 **Board of Directors** 172
2.29.4 **Employment and Contracting Restrictions** 172
2.30 REPORTING REQUIREMENTS 173
2.30.1 **General Requirements** 173
2.30.2 **Eligibility, Enrollment and Disenrollment Reports** 174
2.30.3 **Benefits/Service Requirements and Limits Reports** 174
2.30.4 **Specialized Service Reports** 175
2.30.5 **Disease Management Reports** 176

2.30.6 **Service Coordination Reports** 176
2.30.7 **Provider Network Reports**....177
2.30.8 **Provider Agreement Report** 178
2.30.9 **Provider Payment Report**....178
2.30.10 **Utilization Management Reports** 178
2.30.11 **Quality Management/Quality Improvement Reports** 179
2.30.12 **Customer Service Reports** 179
2.30.13 **Fraud and Abuse Reports**....180
2.30.14 **Financial Management Reports** 180
2.30.15 **Claims Management Reports** 182
2.30.16 **Information Systems Reports**....182
2.30.17 **Administrative Requirements Reports**....183
2.30.18 **Subcontract Reports**....183
2.30.19 **HIPAA Reports**....184
2.30.20 **Non-Discrimination Compliance Reports** 184
2.30.21 **Terms and Conditions Reports** 185
2.31 STATE ONLYS AND JUDICIALS 185
2.31.1 **General** 185
2.31.2 **Applicability of Agreement**....186

SECTION 3 - PAYMENTS TO THE CONTRACTOR....192

3.1 GENERAL PROVISIONS 192
3.2 ANNUAL ACTUARIAL STUDY 192
3.3 CAPITATION PAYMENT RATES....192
3.4 CAPITATION RATE ADJUSTMENT 193
3.5 CAPITATION PAYMENT SCHEDULE 195
3.6 CAPITATION PAYMENT CALCULATION 195
3.7 CAPITATION PAYMENT ADJUSTMENTS....195
3.8 SERVICE DATES 197
3.9 WITHHOLD OF THE CAPITATION RATE....197
3.10 EFFECT OF DISENROLLMENT ON CAPITATION PAYMENTS 198
3.11 HMO PAYMENT TAX....199
3.12 PAYMENT TERMS AND CONDITIONS 199

SECTION 4 - TERMS AND CONDITIONS....201

4.1 NOTICE 201
4.2 AGREEMENT TERM 201
4.3 APPLICABLE LAWS AND REGULATIONS....202
4.4 TERMINATION....204
4.5 ENTIRE AGREEMENT....208
4.6 INCORPORATION OF ADDITIONAL DOCUMENTS 208
4.7 APPLICABILITY OF THIS AGREEMENT....209
4.8 TECHNICAL ASSISTANCE 209
4.9 PROGRAM INFORMATION....209
4.10 QUESTIONS ON POLICY DETERMINATIONS 209
4.11 INTERPRETATIONS....209
4.12 CONTRACTOR APPEAL RIGHTS 210
4.13 DISPUTES....210
4.14 NOTIFICATION OF LEGAL ACTION AGAINST THE CONTRACTOR....210
4.15 DATA THAT MUST BE CERTIFIED....210
4.16 USE OF DATA....211
4.17 WAIVER 211
4.18 AGREEMENT VARIATION/SEVERABILITY....211
4.19 CONFLICT OF INTEREST....211
4.20 FAILURE TO MEET AGREEMENT REQUIREMENTS 212
4.21 MODIFICATION AND AMENDMENT....222

4.22 TITLES/HEADINGS 223
4.23 OFFER OF GRATUITIES 223
4.24 LOBBYING 223
4.25 ATTORNEY'S FEES 223
4.26 GOVERNING LAW AND VENUE 223
4.27 ASSIGNMENT 223
4.28 INDEPENDENT CONTRACTOR 223
4.29 FORCE MAJEURE 224
4.30 DATE/TIME HOLD HARMLESS 224
4.31 INDEMNIFICATION 224
4.32 NON-DISCRIMINATION 225
4.33 CONFIDENTIALITY OF INFORMATION 225
4.34 TENNESSEE CONSOLIDATED RETIREMENT SYSTEM 226
4.35 ACTIONS TAKEN BY THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE 226
4.36 EFFECT OF THE FEDERAL WAIVER ON THIS AGREEMENT 226
4.37 TENNCARE FINANCIAL RESPONSIBILITY 226

ATTACHMENTS **228**

ATTACHMENT I 229
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS 229
ATTACHMENT II 236
COST SHARING SCHEDULE 236
ATTACHMENT III 238
TERMS AND CONDITIONS FOR ACCESS 238
ATTACHMENT IV 241
SPECIALTY NETWORK STANDARDS 241
ATTACHMENT V 244
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES 244
ATTACHMENT VI 246
FORMS FOR REPORTING FRAUD AND ABUSE 246
ATTACHMENT VII 249
PERFORMANCE STANDARDS 249
ATTACHMENT VIII 256
DELIVERABLE REQUIREMENTS 256
ATTACHMENT IX 264
REPORTING REQUIREMENTS 264
ATTACHMENT IX, EXHIBIT A 265
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS 265
ATTACHMENT IX, EXHIBIT B 270
MENTAL HEALTH CASE MANAGEMENT REPORT 270
ATTACHMENT IX, EXHIBIT C 272
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT 272
ATTACHMENT IX, EXHIBIT D 274
MEMBER CRG/TPG ASSESSMENT REPORT 274
ATTACHMENT IX, EXHIBIT E 277
PROVIDER ENROLLMENT FILE 277
ATTACHMENT IX, EXHIBIT F 279
PCP ASSIGNMENT REPORT 279
ATTACHMENT IX, EXHIBIT G 281
REPORT OF ESSENTIAL HOSPITAL SERVICES 281
ATTACHMENT IX, EXHIBIT H 284
FQHC REPORT 284
ATTACHMENT IX, EXHIBIT I 286
SINGLE CASE AGREEMENTS REPORT 286
ATTACHMENT IX, EXHIBIT J 288

COST AND UTILIZATION REPORTS 288
ATTACHMENT IX, EXHIBIT K 309
COST AND UTILIZATION SUMMARIES 309
ATTACHMENT IX, EXHIBIT L 312
PRIOR AUTHORIZATION REPORTS 312
ATTACHMENT IX, EXHIBIT M 315
MEMBER SERVICES AND UTILIZATION MANAGEMENT PHONE LINE REPORT 315
ATTACHMENT IX, EXHIBIT N 318
MEDICAL LOSS RATIO REPORT 318
ATTACHMENT X 326
CAPITATION RATES 326

CONTRACTOR RISK AGREEMENT

BETWEEN

THE STATE OF TENNESSEE, d.b.a. TENNCARE

AND

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

This Agreement is entered into by and between THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" or "State" and UnitedHealthcare Plan of the River Valley, Inc., hereinafter referred to as "the CONTRACTOR".

WHEREAS, the purpose of this Agreement is to assure the provision of quality physical health and behavioral health services while controlling the costs of such services;

WHEREAS, consistent with waivers granted by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to Health Maintenance Organizations (HMOs), referred to as Managed Care Organizations or MCOs, for rendering or arranging necessary physical health and behavioral health services to persons who are enrolled in Tennessee's TennCare program;

WHEREAS, the Tennessee Department of Finance and Administration is the state agency responsible for administration of the TennCare program and is authorized to contract with MCOs for the purpose of providing the services specified herein for the benefit of persons who are eligible for and are enrolled in the TennCare program, State Onlys and Judicials; and

WHEREAS, the CONTRACTOR is a Managed Care Organization as described in the 42 CFR Part 438, is licensed to operate as an HMO in the State of Tennessee, has met additional qualifications established by the State, is capable of providing or arranging for the provision of covered services to persons who are enrolled in the TennCare program and covered behavioral health services to State Onlys and Judicials for whom it has received prepayment, is engaged in said business, and is willing to do so upon and subject to the terms and conditions hereof;

NOW, THEREFORE, in consideration of the mutual promises contained herein the parties have agreed and do hereby enter into this Agreement according to the provisions set forth herein:

SECTION 1 - DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Agreement shall be given the meaning used in TennCare rules and regulations. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Agreement, the specific language in Sections 2 through 4 of this Agreement shall govern.

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

1. Meeting general requirements in Section 2.2;

2. Enrollment and disenrollment in accordance with Section 2.4 and 2.5;

3. Additional services and use of incentives in Section 2.6.6;

4. Health education and outreach in Section 2.7.3;

5. Meeting requirements for coordination of services specified in Section 2.9;

6. Establishing and maintaining a provider network in accordance with the requirements specified in Section 2.11, Attachments III, IV and V;

7. Utilization Management as specified in Section 2.14;

8. Quality Management and Quality Improvement activities as specified in Section 2.15;

9. Production and distribution of Member Materials as specified in Section 2.17;

10. Customer service requirements in Section 2.18;

11. Appeals processing and resolution in accordance with Section 2.19;

12. Determination of recoveries from third party liability resources in accordance with Section 2.21.4;

13. Claims Processing in accordance with Section 2.22;

14. Maintenance and operation of Information Systems in accordance with Section 2.23;

15. Personnel requirements in Section 2.29;

16. Production and submission of required reports as specified in Section 2.30;

17. Administration of this Agreement in accordance with policies and procedures;

18. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;

19. Premium tax; and

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

Adverse Action – Any action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits.

Appeal Procedure – The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rules and regulations and any and all applicable court orders and consent decrees.

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 except for behavioral services for Priority enrollees and for State Onlys and Judicials.

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

Behavioral Health Services – Mental health and substance abuse services.

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

Bureau of TennCare – The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare program. For the purposes of this Agreement, Bureau of TennCare shall mean the State of Tennessee and its representatives.

Business Day – Monday through Friday, except for State of Tennessee holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate various aspects of health care.

Capitation Payment – The fee that is paid by TENNCARE to the CONTRACTOR for each member covered by this Agreement, whether or not the member utilizes services during the payment period. 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, Priority Add-on rate payments, and State Only and Judicials 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 rate, priority add-on rate, and State Only and Judicials rate.

Centers of Excellence (COE) for AIDS – Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare enrollees with HIV or AIDS.

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

CFR – Code of Federal Regulations.

Clean Claim – A claim received by the CONTRACTOR for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CONTRACTOR.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

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

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

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

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

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

CMS – Centers for Medicare & Medicaid Services.

Community Service Area (CSA) – One or more counties in a defined geographical area in which the CONTRACTOR is authorized to enroll and serve TennCare enrollees in exchange for a monthly capitation fee.

The following counties shall constitute the identified Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton Counties
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy Counties
Shelby CSA	-	Shelby County
Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford Counties
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore Counties
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren Counties
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion Counties
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane Counties
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson Counties

Complaint – A written or verbal statement from an enrollee that contests an action taken by the CONTRACTOR or service provider other than an adverse action. The CONTRACTOR shall not treat anything as a complaint that falls within the definition of adverse action.

Contract Provider – A provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide covered services.

Covered Services – See Benefits.

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

CRA – Contractor Risk Agreement; also referred to as "Agreement."

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

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

Group 2 - Persons with Severe Mental Illness (SMI)

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

Group 4 - Persons with Mild or Moderate Mental Disorder

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

Days – Calendar days unless otherwise specified.

Dental Benefits Manager (DBM) – An entity responsible for the provision and administration of dental services, as defined by TENNCARE.

DHHS – United States Department of Health and Human Services.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the enrollment file furnished by TENNCARE to the CONTRACTOR.

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program.

Emergency Medical Condition – A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also).

Enrollment – The process by which a TennCare enrollee becomes a member of the CONTRACTOR's MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

Essential Hospital Services – Tertiary care hospital services to which it is essential for the CONTRACTOR to provide access. Essential hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

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

Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the CONTRACTOR or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractor or provider to provide services on behalf of the CONTRACTOR.

Fee-for-Service – A method of making payment for health services based on a fee schedule that specifies payment for defined services.

FQHC – Federally Qualified Health Center.

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

East Grand Region	Middle Grand Region	West Grand Region
First Tennessee CSA	Upper Cumberland CSA	Northwest CSA
East Tennessee CSA	Mid Cumberland CSA	Southwest CSA
Knox CSA	Davidson CSA	Shelby CSA
Southeast Tennessee CSA	South Central CSA	
Hamilton CSA		

Health Maintenance Organization (HMO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 32.

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

HIPAA – Health Insurance Portability and Accountability Act.

Hospice – Services as described in TennCare rules and regulations and 42 CFR Part 418, which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

Information System(s) (Systems) – A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Institutionalized Medicaid – Individuals who are receiving (as described in TennCare rules and regulations) long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through a Home and Community Based Services (HCBS) waiver as an alternative for these institutional services.

Judicial – An individual who requires judicial services as specified in Section 2.7.2.10 of this Agreement but (1) does not meet eligibility requirements for enrollment in the TennCare program or has a TennCare application pending; and (2) has not been determined to be a State Only participant by TDMHDD. A Judicial is not a TennCare enrollee nor a member of the CONTRACTOR's MCO and is only entitled to coverage of those behavioral health evaluation and treatment services required by state law or by the court order under which the individual was referred. Eligibility criteria for judicial coverage must be met as determined by TDMHDD.

Law – Statutes, codes, rules, regulations, and/or court rulings.

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

Long-Term Care – The services of one of the following: a nursing facility (NF); an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Home and Community Based Services (HCBS) waiver program. (Services provided under a HCBS waiver program are considered to be alternatives to long-term care.)

Managed Care Organization (MCO) – An HMO that participates in the TennCare program.

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

Marketing – Any communication, from the CONTRACTOR to a TennCare enrollee who is not enrolled in the CONTRACTOR's MCO, that can reasonably be interpreted as intended to influence the person to enroll in the CONTRACTOR's MCO, or either to not enroll in, or to disenroll from, another MCO's TennCare product.

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health and behavioral health services to members pursuant to the following listed Sections of the Agreement:

    a. Section 2.6.1, CONTRACTOR Covered Benefits;

    b. Section 2.6.4, Second Opinions;

    c. Section 2.6.5, Use of Cost Effective Alternative Services;

    d. Section 2.7, Specialized Services except TENNderCare member and provider outreach and education, health education and outreach and advance directives;

    e. Capitated payment to licensed providers;

    f. Medical services directed by TENNCARE or an Administrative Law Judge; and

    g. Net impact of reinsurance coverage purchased by the CONTRACTOR.

2. Medical Expenses do not include:

    a. 2.6.2 TennCare Benefits Provided by TENNCARE;

    b. 2.6.7 Cost sharing for services;

    c. 2.10 Services Not Covered;

    d. Services eligible for reimbursement by Medicare; or

    e. The activities described in or required to be conducted in Attachments II through IX, which are administrative costs.

3. Medical expenses will be net of any TPL recoveries or subrogation activities.

4. This definition does not apply to NAIC filings.

Medical Loss Ratio (MLR) – The percentage of capitation payment received from TENNCARE that is used to pay medical expenses.

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

Member – A TennCare enrollee who enrolls in the CONTRACTOR's MCO under the provisions of this Agreement (see Enrollee, also).

Member Month – A month of coverage for a TennCare enrollee enrolled in the CONTRACTOR's MCO.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

NAIC – National Association of Insurance Commissioners.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

Non-Contract Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member's condition.

Prepaid Limited Health Service Organization (PLHSO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 51.

Presumptive Eligibility – An established period of time (45 days) during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete an application for Medicaid in order to stay on the program.

Primary Care Physician – A physician responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is generally a physician who has limited his practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner. However, as provided in Section 2.11.2.4 of this Agreement, in certain circumstances other physicians may be primary care physicians if they are willing and able to carry out all PCP responsibilities in accordance with this Agreement.

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

Prior Authorization – The act of authorizing specific services or activities before they are rendered or occur.

Priority Add-on Rate – The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement as compensation for the provision of behavioral health services for Priority enrollees.

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

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Protected Health Information (PHI) – Identifiable health information as defined in 45 CFR Part 160 and Part 164.

Provider – An institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished.

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between the CONTRACTOR and a provider or between the CONTRACTOR's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the CONTRACTOR's members.

Quality Improvement (QI) – The effort to assess and improve the performance of a program or organization. Quality improvement includes quality assessment and implementation of corrective actions to address any deficiencies identified.

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

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

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

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

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Final Rule adopting Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164.

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

1. Person under the age of 18; and

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

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

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

1. Age 18 and over; and

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

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

Shall – Indicates a mandatory requirement or a condition to be met.

Span of Control – Information systems and telecommunications capabilities that the CONTRACTOR itself operates or for which it is otherwise legally responsible according to this Agreement. The CONTRACTOR's span of control also includes Systems and telecommunications capabilities outsourced by the CONTRACTOR.

Specialty Services – Includes Essential Hospital Services and specialty physician services.

SSI – Supplemental Security Income.

Start Date of Operations – The date, as determined by TENNCARE, when the CONTRACTOR will begin providing services to members.

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Bureau of TennCare, the Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General. State shall also include State representatives.

State Onlys – Uninsured individuals who (1) are not eligible for the TennCare program or have a TennCare application pending; and (2) are determined by TDMHDD, or its designee, to be severely and/or persistently mentally ill (SPMI) or seriously emotionally disturbed (SED) and in need of behavioral health services on an inpatient or outpatient basis. Individuals must meet eligibility criteria specified by TDMHDD.

State Representative – Any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(s) may include, but are not limited to, contractors and federal agencies.

Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, disease management) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Subcontractor – Any organization or person who provides any function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

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

System Unavailability – As measured within the CONTRACTOR's information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

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

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
   Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).

2. Target Population Group 3: At Risk of a (SED)
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.

3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

TCA – Tennessee Code Annotated.

TENNCARE – TENNCARE shall have the same meaning as "State."

TennCare or TennCare Program **–** The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare Medicaid Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in TennCare rules and regulations.

TennCare Select – TennCare Select is a statewide MCO whose risk is backed by the State of Tennessee. TennCare Select was created to serve as a backup if other MCOs failed or there was inadequate MCO capacity and to be the MCO for certain populations, including children in state custody and children eligible for SSI. Children eligible for SSI may opt out of TennCare Select and enroll in another MCO.

TennCare Standard Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver and the TennCare rules and regulations.

TENNderCare – Tennessee's EPSDT program; see EPSDT.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

Tennessee Department of Children's Services (DCS) – The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.

Tennessee Department of Commerce and Insurance (TDCI) – The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

Tennessee Department of Finance and Administration (F&A) – The state agency that oversees all state spending and acts as the chief corporate office of the state. It is the single state Medicaid agency. The Bureau of TennCare is a division of the Tennessee Department of Finance and Administration.

Tennessee Department of Health (DOH) – The state agency having the statutory authority to provide for health care needs in Tennessee.

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency. DHS is responsible for TennCare eligibility determinations (other than presumptive eligibility and SSI).

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) – The state agency having the statutory authority to provide care for persons with mental illness and persons with developmental disabilities. For the purposes of this Agreement, TDMHDD shall mean the State of Tennessee and its representatives.

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

Third Party Resource – Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of health care of the enrollee.

USC – United States Code

Vital MCO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents must be available in Spanish.

SECTION 2 – PROGRAM REQUIREMENTS

2.1 REQUIREMENTS PRIOR TO OPERATIONS

2.1.1 Licensure

2.1.1.1 Prior to the start date of operations (as defined in Section 1 of this Agreement) and prior to accepting TennCare enrollees, the CONTRACTOR shall obtain a standard certificate of authority (COA) from TDCI to operate as an HMO in Tennessee in the service area covered by this Agreement (see Section 2.4.2).

2.1.1.2 Prior to the start date of operations and prior to accepting TennCare enrollees, the CONTRACTOR shall ensure that any subcontractor(s) accepting risk under this Agreement shall be licensed, as necessary, by TDCI. In particular, if the CONTRACTOR subcontracts for the provision of behavioral health services, and that subcontractor accepts risk, TDCI may require that the subcontractor be licensed as a Prepaid Limited Health Service Organization (PLHSO).

2.1.1.3 Prior to the start date of operations, the CONTRACTOR shall ensure that its staff, all subcontractors and providers, and their staff are appropriately licensed.

2.1.1.4 The CONTRACTOR shall ensure that the CONTRACTOR and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Agreement a valid license, as appropriate, and comply with all applicable licensure requirements.

2.1.2 Readiness Review

2.1.2.1 Prior to the start date of operations, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that it is able to meet the requirements of this Agreement.

2.1.2.2 The CONTRACTOR shall cooperate in a "readiness review" conducted by TENNCARE to review the CONTRACTOR's readiness to begin operations. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all requirements of this Agreement as determined by TENNCARE.

2.1.2.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR. TennCare enrollees may not be enrolled with the CONTRACTOR until TENNCARE has determined that the CONTRACTOR is able to meet the requirements of this Agreement.

2.1.2.4 If the CONTRACTOR is unable to demonstrate its ability to meet the requirements of this Agreement, as determined by TENNCARE, within the time frames specified by TENNCARE, TENNCARE may terminate this Agreement in accordance with Section 4.4 of this Agreement and shall have no liability for payment to the CONTRACTOR.

2.2 GENERAL REQUIREMENTS

2.2.1 The CONTRACTOR shall comply with all the provisions of this Agreement and any amendments thereto and shall act in good faith in the performance of these provisions. The CONTRACTOR shall respect the legal rights (including rights conferred by the Agreement) of every enrollee, regardless of the enrollee's family status as head of household, dependent, or otherwise. Nothing in this Agreement may be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with provisions of this Agreement may result in the assessment of liquidated damages and/or termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement.

2.2.2 The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement including all subcontractors, providers, employees, agents, and anyone acting for or on behalf of the CONTRACTOR.

2.3 ELIGIBILITY

2.3.1 Overview

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

2.3.2 Eligibility Categories

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

2.3.2.1 <u>TennCare Medicaid</u>

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

2.3.2.2 <u>TennCare Standard</u>

TennCare Standard includes children in the following eligibility categories:

2.3.2.2.1 Uninsured children under age nineteen (19) with family incomes up to two-hundred percent (200%) of the federal poverty level (FPL) who were eligible for TennCare as of April 29, 2005;

2.3.2.2.2 Uninsured children under age nineteen (19) who meet the "medically eligible" criteria (has a health condition that makes the child uninsurable) and who were eligible for TennCare as of April 29, 2005; and

2.3.2.2.3 Children under age nineteen (19) who are no longer eligible for TennCare Medicaid and who are either uninsured or medically eligible.

2.3.3 **TennCare Applications**

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

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

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

2.3.5 **Eligibility for Enrollment in an MCO**

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

2.4 ENROLLMENT

2.4.1 **General**

TENNCARE is solely responsible for enrollment of TennCare enrollees in an MCO.

2.4.2 **Authorized Service Area**

2.4.2.1 Grand Region

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

2.4.2.2 CONTRACTOR's Authorized Service Area

The CONTRACTOR is authorized under this Agreement to serve enrollees who reside in the Grand Region(s) specified below:

__East Grand Region **X Middle Grand Region** __West Grand Region

2.4.3 **Maximum Enrollment**

2.4.3.1 The CONTRACTOR agrees to accept enrollment in the CONTRACTOR's MCO of up to seventy percent (70%) of the eligible population in the applicable Grand Region. TENNCARE shall determine and notify the CONTRACTOR of the number of eligibles in the applicable Grand Region and the CONTRACTOR's maximum enrollment limit, which shall be approximately seventy percent (70%) of the eligible population in the applicable Grand Region.

2.4.3.2 TENNCARE shall establish an enrollment threshold for the CONTRACTOR that will equal approximately ninety percent (90%) of the maximum enrollment limit established in Section 2.4.3.1 above. This enrollment threshold may be adjusted by TENNCARE at its discretion.

2.4.3.3 Once the CONTRACTOR's enrollment threshold is met, TENNCARE may discontinue default assignment of enrollees to the CONTRACTOR's MCO. Enrollees who select the CONTRACTOR or whose family members are enrolled in the CONTRACTOR's MCO shall continue to be enrolled in the CONTRACTOR's MCO until the maximum enrollment limit established in Section 2.4.3.1 above is met.

2.4.3.4 Both TENNCARE and the CONTRACTOR recognize that management of the CONTRACTOR's maximum enrollment limit and enrollment threshold within exact limits may not be possible. In the event enrollment in the CONTRACTOR's MCO exceeds the maximum enrollment limit, TENNCARE may reduce enrollment in the CONTRACTOR's MCO based on a plan established by TENNCARE that provides appropriate notice to the CONTRACTOR, allows appropriate choice of MCOs for enrollees, and meets the objectives of the TennCare program.

2.4.3.5 The establishment of a maximum enrollment limit and/or of an enrollment threshold does not obligate the State to enroll a certain number of TennCare enrollees in the CONTRACTOR's MCO and does not create in the CONTRACTOR any rights, interests or claims of entitlement to enrollment. The CONTRACTOR's actual enrollment level will be determined through the MCO selection and assignment process described in Section 2.4.4 below.

2.4.3.6 The CONTRACTOR shall demonstrate to the satisfaction of TENNCARE it has the capacity to serve the number of enrollees in the maximum enrollment limit prior to the assignment of any enrollees.

2.4.4 MCO Selection and Assignment

2.4.4.1 General

TENNCARE shall enroll individuals determined eligible for TennCare and eligible for enrollment in an MCO that is available in the Grand Region in which the enrollee resides. Enrollment in an MCO may be the result of an enrollee's selection of a particular MCO or assignment by TENNCARE. Enrollment in the CONTRACTOR's MCO is subject to the CONTRACTOR's maximum enrollment limit and threshold (see Section 2.4.3) and capacity to accept additional members.

2.4.4.2 Current TennCare Enrollees

TennCare enrollees who are known to be eligible for enrollment with the CONTRACTOR as of the start date of operations (defined in Section 1 of this Agreement) and residing in the Grand Region served by the CONTRACTOR shall be assigned by TENNCARE to the MCOs serving the Grand Region in accordance with the process described in Section 2.4.4.6 below. Except as otherwise provided in Section 2.4.4, this includes individuals currently enrolled in another MCO, including TennCare Select.

2.4.4.3 New TennCare Enrollees

2.4.4.3.1 Except as otherwise provided in this Agreement, all non-SSI applicants shall be required at the time of their application to select an MCO other than TennCare Select from those MCOs available in the Grand Region where the applicant resides. If the applicant does not select an MCO, the person will be assigned to an MCO by the State in accordance with Section 2.4.4.6.

2.4.4.3.2 Adults eligible for TennCare as a result of being eligible for SSI benefits will be assigned to an MCO (other than TennCare Select) by the State.

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

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

2.4.4.4 Children in State Custody

TennCare enrollees who are children in the custody of the Department of Children's Services (DCS) will be enrolled in TennCare Select. When these enrollees exit state custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled from TennCare Select. After disenrollment from TennCare Select, if the enrollee has a family member in an MCO (other than TennCare Select) he/she will be enrolled in that MCO. Otherwise, the enrollee will be given the opportunity to select another MCO. If the enrollee does not select another MCO, he/she will be assigned to an MCO (other than TennCare Select) using the default logic in the auto assignment process (see Section 2.4.4.6 below).

2.4.4.5 Enrollment in MCO Other than the MCO Selected

In certain circumstances, if an enrollee requests enrollment in a particular MCO, the enrollee may be assigned by the State to an MCO other than the one that he/she requested. Examples of circumstances when an enrollee would not be enrolled in the requested MCO include, but are not limited to, such factors as the enrollee does not reside in the Grand Region covered by the requested MCO, the enrollee has other family members already enrolled in a different MCO, the MCO is closed to new TennCare enrollment, or the enrollee is a member of a population that is to be enrolled in a specified MCO as defined by TENNCARE (e.g., children in the custody of the Department of Children's Services are enrolled in TennCare Select).

2.4.4.6 Auto Assignment

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

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

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

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

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

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

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

2.4.4.6.4 TENNCARE may modify the auto assignment algorithm to change or add criteria including but not limited to quality measures.

2.4.4.7 Non-Discrimination

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

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

2.4.4.8 Family Unit

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

2.4.5 Effective Date of Enrollment

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

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

2.4.5.2 Ongoing Enrollment

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

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations. Although the enrollee is not a member of the CONTRACTOR's MCO prior to the start date of operations, the CONTRACTOR shall be responsible for the payment of claims incurred by the enrollee during the period of eligibility prior to the start date of operations as specified in Section 3.7.1.2.1.

2.4.5.4 Enrollment Prior to Notification

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

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

2.4.5.4.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, payment shall be made in accordance with Section 3.7.1.2.1.

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

2.4.6 **Eligibility and Enrollment Data**

2.4.6.1 The CONTRACTOR shall receive, process, and update enrollment files from TENNCARE. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE.

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

2.4.7 **Enrollment Period**

2.4.7.1 General

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

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

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

2.4.7.2 Changing MCOs

2.4.7.2.1 *45-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), enrollees shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCOs. Children eligible for TennCare as a result or being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select.

2.4.7.2.2 *Annual Choice Period*

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

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

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

2.4.7.2.3 *Appeal Based on Hardship Criteria*

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

2.4.7.2.4 *Additional Reasons for Disenrollment*

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

2.4.7.3 Member Moving out of Grand Region

The CONTRACTOR shall be responsible for the provision and cost of all covered services for any member moving outside the CONTRACTOR's Grand Region until the member is disenrolled by TENNCARE. TENNCARE shall continue to make payments to the CONTRACTOR on behalf of the enrollee until such time as the enrollee is enrolled in another MCO or otherwise disenrolled by TENNCARE (e.g., enrollee is terminated from the TennCare program). TENNCARE shall notify the CONTRACTOR promptly upon enrollment of the enrollee in another MCO.

2.4.8 **Transfers from Other MCOs**

2.4.8.1 The CONTRACTOR shall accept enrollees (enrolled or pending enrollment) from any MCO in the CONTRACTOR's service area as authorized by TENNCARE. The transfer of membership may occur at any time during the year. No enrollee from another MCO shall be transferred retroactively to the CONTRACTOR except as specified in Section 2.4.9. Except as provided in Section 2.4.9, the CONTRACTOR shall not be responsible for payment of any covered services incurred by enrollees transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

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

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

2.4.9 **Enrollment of Newborns**

2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.

2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.

2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:

2.4.9.3.1 Disenroll the newborn from the incorrect MCO;

2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO;

2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and

2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.

2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the capitation payment to the correct MCO.

2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

2.4.10 **Information Requirements Upon Enrollment**

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

2.5 DISENROLLMENT FROM AN MCO

2.5.1 **General**

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

2.5.2 **Acceptable Reasons for Disenrollment from an MCO**

A member may request disenrollment or be disenrolled from the CONTRACTOR's MCO if:

2.5.2.1 The member selects another MCO during the forty-five (45) day change period after enrollment with the CONTRACTOR's MCO and is enrolled in another MCO;

2.5.2.2 The member selects another MCO during the annual choice period and is enrolled in another MCO;

2.5.2.3 An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TENNCARE in favor of the member, and the member is enrolled in another MCO;

2.5.2.4 The member is assigned incorrectly to the CONTRACTOR's MCO by TENNCARE and enrolled in another MCO;

2.5.2.5 The member moves outside the MCO's service area and is enrolled in another MCO;

2.5.2.6 During the appeal process, if TENNCARE determines it is in the best interest of the enrollee and TENNCARE (see Section 2.19.2.9);

2.5.2.7 The member loses eligibility for TennCare;

2.5.2.8 TENNCARE grants members the right to terminate enrollment pursuant to Section 4.20.1, and the member is enrolled in another MCO;

2.5.2.9 The CONTRACTOR no longer participates in TennCare; or

2.5.2.10 This Agreement expires or is terminated.

2.5.3 **Unacceptable Reasons for Disenrollment from an MCO**

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

2.5.3.1 Adverse changes in the enrollee's health;

2.5.3.2 Pre-existing medical or behavioral health conditions;

2.5.3.3 High cost medical or behavioral health bills;

2.5.3.4 Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;

2.5.3.5 Enrollee's utilization of medical or behavioral health services;

2.5.3.6 Enrollee's diminished mental capacity; or

2.5.3.7 Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

2.5.4 Informing TENNCARE of Potential Ineligibility

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

2.5.5 Effective Date of Disenrollment

2.5.5.1 Member Requested Disenrollment

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

2.5.5.2 Other Disenrollments

The effective date of disenrollments other than at the request of the member shall be determined by TENNCARE and indicated on the termination record.

2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS

2.6.1 CONTRACTOR Covered Benefits

2.6.1.1 The CONTRACTOR shall cover the physical health and behavioral health services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.7.2 and Attachment I.

2.6.1.2 CONTRACTOR Physical Health Benefits Chart

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		**Medicaid Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** As medically necessary, including rehabilitation hospital facility.
Outpatient Hospital Services		As medically necessary.
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.
TENNderCare Services		**Medicaid Eligibles, Age 21 and older:** Not covered. **Medicaid/Standard Eligibles, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.5.
Preventive Care Services		As described in Section 2.7.4.
Lab and X-ray Services		As medically necessary.
Hospice Care		As medically necessary. Must be provided by a Medicare-certified hospice.

SERVICE		BENEFIT LIMIT
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager.** However, the provision of transportation to and from said services as well as the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.
Vision Services		**Medicaid Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENNderCare requirements.
Home Health Care		As medically necessary in accordance with Newberry.
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).
Durable Medical Equipment		As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.

SERVICE		BENEFIT LIMIT
Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Transportation (including Non-Emergency Ambulance Transportation)		As necessary to get a member to and from covered services, dental services (provided by the DBM), and pharmacy services (provided through the PBM) for enrollees not having access to transportation. If the CONTRACTOR is unable to meet the access standards included in this Agreement (see Section 2.11) for a member, transportation must be provided regardless of whether or not the member has access to transportation. If the member is a child, transportation must be provided in accordance with TENNderCare requirements (see Section 2.7.5.4.6). As with any denial, all notices and actions must be in accordance with the requirements of this Agreement (see Section 2.14.2.2 and Section 2.19). The CONTRACTOR may require advance notice of the need for transportation in order to timely arrange transportation. The CONTRACTOR shall contract with the transportation vendor selected by the State and shall pay the vendor the rate determined by TENNCARE at such time that TENNCARE enters into an agreement with a transportation vendor.
Renal Dialysis Services		As medically necessary.
Private Duty Nursing		As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy		**Medicaid Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

SERVICE		BENEFIT LIMIT
Occupational Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Physical Therapy		**Medicaid Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Organ and Tissue Transplant And Donor Organ Procurement		**Medicaid Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery		Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.

SERVICE		BENEFIT LIMIT
Chiropractic Services		**Medicaid Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

2.6.1.3 Soft Limits/Service Thresholds for Certain Physical Health Services

2.6.1.3.1 TENNCARE has established thresholds that apply to certain covered physical health services for non-institutionalized Medicaid adults. The CONTRACTOR shall track, in a manner prescribed by TENNCARE, and report on accumulated benefit information for each service that has a threshold. Depending on the service, once a member reaches a threshold, the CONTRACTOR shall enroll the member in MCO case management or a disease management program or shall determine whether the person should be enrolled in MCO case management or a disease management program.

2.6.1.3.2 The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program, whichever is more appropriate
Outpatient Hospital Services	8 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	12 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Lab and X-ray Services	10 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate

2.6.1.3.3 As provided in Section 2.30.3, the CONTRACTOR shall report on the number of members who reach each threshold, were assessed, and/or were enrolled in MCO case management or a disease management program, and the reasons for failure to enroll in MCO case management or disease management.

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE		BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)		As medically necessary.
24-hour Psychiatric Residential Treatment		**Medicaid Eligible, Age 21 and older:** As medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services)		As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits[1]		**Medicaid Eligible, Age 21 and older:** Limited to ten (10) days detox, $30,000 in medically necessary lifetime benefits. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Mental Health Case Management		As medically necessary.
Psychiatric-Rehabilitation Services		As medically necessary.
Behavioral Health Crisis Services		As necessary.
Lab and X-ray Services		As medically necessary.
Non-emergency Transportation (including Non-Emergency Ambulance Transportation)		Same as for physical health (see Section 2.6.1.2 above).

[1]When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2.6.2 **TennCare Benefits Provided by TENNCARE**

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.2 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TENNCARE. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.2 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TENNCARE. Coverage of pharmacy services is described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 Institutional Services and Alternatives to Institutional Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or alternatives to institutional services provided through the Home and Community Based Services (HCBS) waivers.

2.6.3 **Medical Necessity Determination**

2.6.3.1 The CONTRACTOR may establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and TennCare rules and regulations. However, this requirement shall not limit the CONTRACTOR's ability to use medically appropriate cost effective alternatives in accordance with Section 2.6.5.

2.6.3.2 The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded (up to the applicable hard limit on detoxification provided in Section 2.6.1.4 above) when medically necessary based on a member's individual characteristics.

2.6.3.3 The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

2.6.3.4 The CONTRACTOR may deny services that are non-covered except as otherwise required by TENNderCare or unless otherwise directed to provide by TENNCARE and/or an administrative law judge.

2.6.3.5 All medically necessary services shall be covered for enrollees under twenty-one (21) years of age in accordance with TENNderCare requirements (see Section 2.7.5).

2.6.4 **Second Opinions**

The CONTRACTOR shall provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent and/or legally appointed representative. The second opinion must be provided by a contracted qualified health care professional or the CONTRACTOR shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.

2.6.5 **Use of Cost Effective Alternative Services**

The CONTRACTOR shall be allowed to use cost effective alternative services, whether listed as covered or non-covered or omitted in Section 2.6.1 of this Agreement, when the use of such alternative services is medically appropriate and is cost effective. This may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation. The CONTRACTOR shall comply with TennCare policies and procedures. As provided in the applicable TennCare policies and procedures, services not listed in the TennCare policies and procedures must be prior approved in writing by TENNCARE and CMS.

2.6.6 **Additional Services and Use of Incentives**

The CONTRACTOR shall not advertise, offer or provide any services that are not required by this Agreement other than those permitted pursuant to Section 2.6.1 of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in disease management programs.

2.6.7 **Cost Sharing for Services**

2.6.7.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by the State to the CONTRACTOR. Further, the CONTRACTOR and all providers and subcontractors may not charge enrollees for missed appointments.

2.6.7.2 Preventive Services

TennCare cost sharing responsibilities shall apply to covered services other than the preventive services described in TennCare rules and regulations.

2.6.7.3 Cost Sharing Schedule

The current TennCare cost sharing schedule is included in this Agreement as Attachment II. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TENNCARE.

2.6.7.4 Provider Requirements

2.6.7.4.1 Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for covered services, including but not limited to, services that the State or the CONTRACTOR has not paid for, except as permitted by TennCare rules and regulations and as described below. Providers may seek payment from an enrollee only in the following situations.

2.6.7.4.1.1 If the services are not covered services and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider must inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.7.4.1.2 If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.7.4.1.3 If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts must be refunded when a claim is submitted to an MCO because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

2.6.7.4.1.4 If the services are not covered because they are in excess of an enrollee's hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

2.6.7.4.2 The CONTRACTOR shall require, as a condition of payment, that the provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for

the service. Except in the circumstances described above, if the CONTRACTOR is aware that a provider, or a collection agency acting on the provider's behalf, bills an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. If a provider continues to bill an enrollee after notification by the CONTRACTOR, the CONTRACTOR shall refer the provider to the Tennessee Bureau of Investigation.

2.7 SPECIALIZED SERVICES

2.7.1 Emergency Services

2.7.1.1 Emergency services (as defined in Section 1 of this Agreement) shall be available twenty-four (24) hours a day, seven (7) days a week.

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.

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.

2.7.1.4 If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member. The CONTRACTOR shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility. If there is a disagreement between the hospital and the CONTRACTOR concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending provider(s) actually caring for the member at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR, however, may establish arrangements with a hospital whereby the CONTRACTOR may send one of

its own providers with appropriate emergency room privileges to assume the attending provider's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

2.7.1.5 The CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. In such cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard regardless of final diagnosis.

2.7.1.6 When the member's PCP or the CONTRACTOR instructs the member to seek emergency services, the CONTRACTOR shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the member's condition meets the prudent layperson standard.

2.7.1.7 Once the member's condition is stabilized, the CONTRACTOR may require prior authorization for hospital admission or follow-up care.

2.7.2 **Behavioral Health Services**

2.7.2.1 <u>General Provisions</u>

2.7.2.1.1 The CONTRACTOR shall provide all behavioral health services as described in this Section, Section 2.6.1 and Attachment I.

2.7.2.1.2 The CONTRACTOR shall provide behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the State.

2.7.2.1.3 The CONTRACTOR shall ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Providers included in this requirement are:

2.7.2.1.3.1 Community mental health agencies;

2.7.2.1.3.2 Case management agencies;

2.7.2.1.3.3 Psychiatric rehabilitation agencies;

2.7.2.1.3.4 Psychiatric and substance abuse residential treatment facilities; and

2.7.2.1.3.5 Psychiatric and substance abuse inpatient facilities.

2.7.2.1.4 Individualized treatment plans shall be completed within thirty (30) calendar days of the start date of service and updated every six (6) months, or more frequently as clinically appropriate. The treatment plans shall be developed, negotiated and agreed upon by the members and/or their support systems in face-to-face encounters and shall be used to identify the treatment needs necessary to meet the members' stated goals. The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.

2.7.2.2 Psychiatric Inpatient Hospital Services

2.7.2.2.1 The CONTRACTOR shall ensure that all psychiatric inpatient hospitals serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are JCAHO accredited and accept voluntary and involuntary admissions.

2.7.2.3 24-Hour Psychiatric Residential Treatment

2.7.2.3.1 The CONTRACTOR shall ensure that 24-hour psychiatric residential treatment facilities (RTFs) serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.3.2 The CONTRACTOR shall ensure RTFs have the capacity to render short term crisis stabilization and long-term treatment and rehabilitation.

2.7.2.3.3 The CONTRACTOR shall ensure all RTFs meet local housing codes.

2.7.2.3.4 The CONTRACTOR shall ensure all RTFs are accredited by a State-recognized accreditation organization as required by 42 CFR 441.151.

2.7.2.4 Outpatient Mental Health Services

2.7.2.4.1 The CONTRACTOR shall ensure that outpatient mental health providers (including providers of intensive outpatient and providers of partial hospitalization services) serving children, youth and adults separate members by age and render developmental age appropriate services.

2.7.2.4.2 The CONTRACTOR shall ensure outpatient mental health providers are capable of rendering services both on and off site, as appropriate, depending on the services being rendered. On site services include, but are not limited to intensive outpatient services, partial hospitalization and many types of therapy. Off site services include but are not limited to intensive in home service for children and youth and home and community treatment for adults.

2.7.2.5 Inpatient, Residential & Outpatient Substance Abuse Services

2.7.2.5.1 The CONTRACTOR shall provide substance abuse treatment through inpatient, residential and outpatient services.

2.7.2.5.2 Detoxification services may be rendered as part of inpatient, residential or outpatient services, as clinically appropriate. The CONTRACTOR shall ensure all member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluations by a physician or a registered nurse.

2.7.2.6 Mental Health Case Management

2.7.2.6.1 The CONTRACTOR shall provide mental health case management services only through providers licensed by the State to provide mental health outpatient services.

2.7.2.6.2 The CONTRACTOR shall provide mental health case management services according to mental health case management standards set by the State and outlined in Attachment I. Mental health case management services will consist of two (2) levels of service as specified in Attachment I.

2.7.2.6.3 The CONTRACTOR shall require its providers to collect and submit individual encounter records for each mental health case management visit, regardless of the method of payment by the CONTRACTOR. The CONTRACTOR shall identify and separately report "level 1" and "level 2" mental health case management encounters outlined in Attachment I.

2.7.2.6.4 The CONTRACTOR shall require mental health case managers to involve the member, the member's family or parent(s), or legally appointed representative, PCP and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.

.

2.7.2.6.5 The CONTRACTOR shall ensure the continuing provision of mental health case management services to members under the conditions and time frames indicated below:

2.7.2.6.5.1 Members receiving mental health case management services at the start date of operations shall be maintained in mental health case management until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;

2.7.2.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be evaluated for mental health case management services and provided with appropriate behavioral health follow-up services; and

2.7.2.6.5.3 The CONTRACTOR shall review the cases of members referred by PCPs or otherwise identified to the CONTRACTOR as potentially in need of mental health case management services and shall contact and offer such services to all members who meet medical necessity criteria.

2.7.2.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer support, illness management and

recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

2.7.2.8 Behavioral Health Crisis Services

2.7.2.8.1 *Entry into the Behavioral Health Crisis Services System*

2.7.2.8.1.1 The State shall maintain a statewide toll-free telephone number for entry into the behavioral health crisis system. This line shall be for any individual in the general population for the purposes of providing immediate phone intervention by trained crisis specialists and dispatch of mobile crisis teams.

2.7.2.8.1.2 The CONTRACTOR shall ensure that the crisis telephone line is linked to an appropriate crisis service team staffed by qualified crisis service providers in order to provide crisis intervention services to members.

2.7.2.8.1.3 As required in Section 2.11.5.3, the CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by the State.

2.7.2.8.1.4 The CONTRACTOR shall require the crisis service teams to provide telephone and walk-in triage screening services, telephone and face-to-face crisis intervention/assessment services, and follow-up telephone or face-to-face assessments to ensure the safety of the member until the member's treatment begins and/or the crisis is alleviated and/or stabilized.

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that the member has been evaluated by a crisis team. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI and determine whether all available less drastic alternatives services and supports are unsuitable.

2.7.2.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

2.7.2.8.2.1 The CONTRACTOR shall ensure access to behavioral health crisis respite and crisis stabilization services.

2.7.2.8.2.2 Behavioral health crisis respite services provide immediate shelter to members with emotional/behavioral problems who are in need of emergency respite. The CONTRACTOR shall ensure that behavioral health crisis respite services are provided in a CONTRACTOR approved community location.

2.7.2.8.2.3 The CONTRACTOR shall ensure behavioral health crisis stabilization services are rendered at sites licensed by the State. These services are more intensive than regular behavioral health crisis services in that they require more secure environments, highly trained staff, and typically have longer stays.

2.7.2.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE on a quarterly basis as described in Section 2.30.4.4.

2.7.2.9 Clinically Related Group (CRG) and Target Population Group (TPG) Assessments

2.7.2.9.1 The CONTRACTOR shall provide CRG/TPG assessments in response to requests from members or legally appointed representatives or, in the case of minors, the members' parents or legally appointed representatives, behavioral health providers, PCPs, or the State.

2.7.2.9.2 The CONTRACTOR shall complete CRG/TPG assessments within fourteen (14) calendar days of the requests. The CONTRACTOR shall not require prior authorization in order for a member to receive a CRG/TPG assessment.

2.7.2.9.3 The CONTRACTOR shall ensure that its contract providers are trained and that there is sufficient capacity to perform CRG/TPG assessments. The CONTRACTOR shall require providers to use the CRG/TPG assessment form(s) as appropriate, prescribed by and in accordance with the policies of the state. The CRG/TPG assessments shall be subject to review and approval by the State.

2.7.2.9.4 The CONTRACTOR shall identify persons in need of CRG/TPG assessments. The CONTRACTOR shall use the CRG/TPG assessments to identify persons who are SPMI or SED for reporting and tracking purposes, in accordance with the definitions contained in Section 1.

2.7.2.9.5 The CONTRACTOR shall ensure that providers who perform CRG/TPG assessments have been trained and authorized by the State to perform CRG/TPG assessments. Certified trainers will be responsible for providing rater training within their agencies.

2.7.2.9.6 The CONTRACTOR shall reject all CRG/TPG assessments completed by unapproved raters. The CONTRACTOR shall report on rejected assessments as required in Section 2.30.4.6.

2.7.2.9.7 The CONTRACTOR shall conduct audits of CRG/TPG assessments for accuracy and conformity to state policies and procedures. The CONTRACTOR shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits and the results of these audits shall be reported as required in Sections 2.30.4.7 and 2.30.4.8.

2.7.2.10 Judicial Services

2.7.2.10.1 The CONTRACTOR shall provide covered court ordered behavioral health services to its members pursuant to court order(s). The CONTRACTOR shall furnish these services in the same manner as services furnished to other members.

2.7.2.10.2 The CONTRACTOR shall provide for behavioral health services to its members in accordance with state law. Specific laws employed include the following:

2.7.2.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release;

2.7.2.10.2.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (TCA 33-6-708);

2.7.2.10.2.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (TCA 33-6, Part 6);

2.7.2.10.2.4 Inpatient psychiatric examination for up to forty-eight (48) hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (TCA 33-3-607);

2.7.2.10.2.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (TCA 33-6, Part 2); and

2.7.2.10.2.6 Voluntary psychiatric hospitalization for persons with a severe impairment when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA 33-6, Part 3).

2.7.2.11 Mandatory Outpatient Treatment

2.7.2.11.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a sixty (60) to ninety (90) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).

2.7.2.11.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.7.2.11.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

2.7.3 **Health Education and Outreach**

2.7.3.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities may include the following:

2.7.3.1.1 General physical and behavioral health education classes;

2.7.3.1.2 Mental illness awareness programs and education campaigns with special emphasis on events such as National Mental Health Month and National Depression Screening Day;

2.7.3.1.3 Smoking cessation programs with targeted outreach for adolescents and pregnant women;

2.7.3.1.4 Nutrition counseling;

2.7.3.1.5 Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;

2.7.3.1.6 Prevention and treatment of alcohol and substance abuse;

2.7.3.1.7 Self care training, including self-examination;

2.7.3.1.8 Need for clear understanding of how to take medications and the importance of coordinating all medications;

2.7.3.1.9 Understanding the difference between emergent, urgent and routine health conditions;

2.7.3.1.10 Telephone calls, mailings and home visits to current members for the sole purpose of educating current members about services offered by or available through the CONTRACTOR's MCO; and

2.7.3.1.11 General activities that benefit the entire community (e.g., health fairs and school activity sponsorships).

2.7.3.2 The CONTRACTOR shall report on these activities as required in Section 2.30.4.9.

2.7.4 **Preventive Services**

2.7.4.1 The CONTRACTOR shall provide preventive services which includes, but is not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities described in Section 2.6.7 of this Agreement (see TennCare rules and regulations for service codes).

2.7.4.2 <u>Prenatal Care</u>

2.7.4.2.1 The CONTRACTOR is required to provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the appointment shall occur as required in Section 2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections 2.9.2.2 and 2.9.2.3 regarding prior authorization of prenatal care.

2.7.4.2.2 Failure of the CONTRACTOR to respond to a member's request for prenatal care by failing to identify a prenatal care provider to honor a request from a member, including a presumptively eligible member, (or from an PCP or patient advocate acting on behalf of a member) for a prenatal care appointment shall be considered a material breach of this Agreement.

2.7.4.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section 2.11.4 of this Agreement.

2.7.5 **TENNderCare**

2.7.5.1 General Provisions

2.7.5.1.1 The CONTRACTOR shall provide TENNderCare services to members under age twenty-one (21) in accordance with TennCare and federal requirements including TennCare rules and regulations, TennCare policies and procedures, 42 USC 1396a(a)(43), 1396d(a) and (r), 42 CFR Part 441, Subpart B, the Omnibus Budget Reconciliation Act of 1989, and the State Medicaid Manual. TENNderCare services means early and periodic screening, diagnosis and treatment of members under age twenty-one (21) to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit as described in Section 2.6.1.

2.7.5.1.2 The CONTRACTOR shall use the name "TENNderCare" in describing or naming the State's EPSDT program or services. This requirement is applicable for all policies, procedures and other material, regardless of the format or media. No other names or labels shall be used.

2.7.5.1.3 The CONTRACTOR shall have written policies and procedures for the TENNderCare program that include coordinating services with child-serving agencies and providers, providing all medically necessary TENNderCare services to all eligible members under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, and conducting outreach and education. The CONTRACTOR shall ensure the availability and accessibility of required health care resources and shall help members and their parents or legally appointed representatives use these resources effectively.

2.7.5.1.4 The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit).

2.7.5.1.5 The CONTRACTOR shall:

2.7.5.1.5.1 Require that providers provide TENNderCare services;

2.7.5.1.5.2 Require that providers make appropriate referrals and document said referrals in the member's medical record;

2.7.5.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TENNderCare services;

2.7.5.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers; and

2.7.5.1.5.5 Monitor provider compliance with required TENNderCare activities including compliance with proper coding.

2.7.5.1.6 The CONTRACTOR shall require that its contract providers notify the CONTRACTOR in the event a screening reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability to make an appropriate referral, the CONTRACTOR shall secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation. In the event the failed referral is for dental services, the CONTRACTOR shall coordinate with the DBM to arrange for services.

2.7.5.1.7 The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary covered services regardless of whether the need for such services was identified by a provider who had received prior authorization from the CONTRACTOR or from a contract provider.

2.7.5.1.8 The CONTRACTOR shall have a tracking system to monitor each TENNderCare eligible member's receipt of the required screening, diagnosis, and treatment services as well as all referrals made as a result of a TENNderCare screen. The tracking system shall have the ability to generate immediate reports on each member's TENNderCare status, reflecting all encounters reported more than sixty (60) days prior to the date of the report.

2.7.5.1.9 In the event that a member under sixteen (16) years of age is seeking behavioral health TENNderCare services and the member's parent(s), or legally appointed representative is unable to accompany the member to the examination, the CONTRACTOR shall require that its providers either contact the member's parent(s), or legally appointed representative to discuss the findings and inform the family of any other necessary health care, diagnostic services, treatment or other measures recommended for the member or notify the MCO to contact the parent(s), or legally appointed representative with the results.

2.7.5.2 <u>Member Education and Outreach</u>

2.7.5.2.1 The CONTRACTOR shall be responsible for outreach activities and for informing members who are under the age of twenty-one (21), or their parent or legally appointed representative, of the availability of TENNderCare services. All TENNderCare member materials shall be submitted to TENNCARE for approval prior to distribution in accordance with Section 2.17.1 and shall be made available in accordance with the requirements specified in Section 2.17.2.

2.7.5.2.2 The CONTRACTOR shall have a minimum of six (6) “outreach contacts” per member per calendar year in which it provides information about TENNderCare to members. The minimum “outreach contacts” include: one (1) member handbook as described in Section 2.17.4, four (4) quarterly member newsletters as described in Section 2.17.5, and one (1) reminder notice issued before a screening is due. The reminder notice shall include an offer of transportation and scheduling assistance.

2.7.5.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TENNderCare screens are due.

2.7.5.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a process for following up with members who do not get their screenings timely. This process for follow up must include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) “outreach contacts” to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

2.7.5.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TENNderCare has used no services within a year and shall make two (2) reasonable attempts to re-notify such members about TENNderCare. One (1) of these attempts can be a referral to DOH. (These two (2) attempts are in addition to the one (1) attempt per quarter mentioned in Section 2.7.5.2.4 above.)

2.7.5.2.6 The CONTRACTOR shall require that providers have a process for documenting services declined by a parent or legally appointed representative or mature competent child, specifying the particular service was declined. This process must meet all requirements outlined in Section 5320.2.A of the State Medicaid Manual.

2.7.5.2.7 The CONTRACTOR shall make and document a minimum of two (2) reasonable attempts to find a member when mail is returned as undeliverable. At least one (1) of these attempts must be oral.

2.7.5.2.8 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section 2.17.7 of this Agreement.

2.7.5.2.9 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TENNderCare services for their children. The CONTRACTOR shall offer TENNderCare services for the child when it is born.

2.7.5.3 Screening

2.7.5.3.1 The CONTRACTOR shall provide periodic comprehensive child health assessments meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth."

2.7.5.3.2 At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare web site. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.

2.7.5.3.3 The screens shall include, but not be limited to:

2.7.5.3.3.1 Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);

2.7.5.3.3.2 Comprehensive unclothed physical examination, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender);

2.7.5.3.3.3 Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;

2.7.5.3.3.4 Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;

2.7.5.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test equal to or greater than ten (10) ug/dL obtained by capillary specimen (finger stick) must be confirmed by using a venous blood sample; and

2.7.5.3.3.6 Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members' parents or to the legally appointed representative to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

2.7.5.3.4 The CONTRACTOR shall encourage providers to refer children to dentists for periodic dental screens beginning no later than three (3) years of age and earlier as needed (as early as six (6) to twelve (12) months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate.

2.7.5.3.5 The CONTRACTOR shall establish a procedure for PCPs or other providers completing TENNderCare screenings to refer TENNderCare eligible members requiring behavioral health services to appropriate providers.

2.7.5.4 Services

2.7.5.4.1 Should screenings indicate a need, the CONTRACTOR must provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section 2.7.5.4.8). This includes, but is not limited to, the services detailed below.

2.7.5.4.2 The CONTRACTOR shall provide treatment for defects in vision and hearing, including eyeglasses and hearing aids.

2.7.5.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TENNderCare eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.

2.7.5.4.4 The CONTRACTOR shall not require prior authorization or written PCP referral in order for a member to obtain a mental health or substance abuse assessment, whether the assessment is requested as follow-up to a TENNderCare screening or an interperiodic screening. This requirement shall not preclude the CONTRACTOR from requiring notification for a referral for an assessment. Furthermore, the CONTRACTOR shall establish a procedure for PCPs, or other providers, completing TENNderCare screenings, to refer members under the age of twenty-one (21) for a mental health or substance abuse assessment.

2.7.5.4.5 For services not covered by Section 1905(a) of the Social Security Act, but found to be needed as a result of conditions disclosed during screening and diagnosis, the CONTRACTOR shall provide referral assistance as required by 42 CFR 441.61, including referral to providers and State health agencies.

2.7.5.4.6 *Transportation Services*

2.7.5.4.6.1 The CONTRACTOR shall provide transportation assistance for a child. This includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary.

2.7.5.4.6.2 The CONTRACTOR shall not impose blanket restrictions when determining coverage for transportation services. Each determination shall be based on individualized circumstances for each case by the CONTRACTOR and/or the transportation vendor. Each request for transportation services is to be reviewed individually and documented by the CONTRACTOR and/or the transportation vendor.

2.7.5.4.6.3 The requirement to provide the cost of meals shall not be interpreted to mean that a member and/or an attendant can request meals while in transport to and from care. Rather, this provision is intended for use when a member has to be transported to a major health facility for services and care cannot be completed in one day thereby requiring an overnight stay.

2.7.5.4.6.4 The CONTRACTOR shall offer transportation and scheduling assistance to all members under age twenty-one (21) who do not have access to transportation in order to access covered services. This may be accomplished through various means of communication to members, including but not limited to, member handbooks, TENNderCare outreach notifications, etc.

2.7.5.4.6.5 Circumstances that may permit the CONTRACTOR and/or its transportation vendor to refuse the transportation request would be when the member or attendant according to a reasonable person's standards is noticeably indisposed (disorderly conduct, intoxicated, armed (firearms), is in possession of illegal drugs, knives and/or other weapons) or is in any other condition that may affect the safety of the driver or persons being transported.

2.7.5.4.7 *Services for Elevated Blood Lead Levels*

2.7.5.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels in accordance with the State Medicaid Manual, Part 5. The Manual currently says that children with blood lead levels equal to or greater than ten (10) ug/dL should be followed according to CDC guidelines. These guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

2.7.5.4.7.2 The CONTRACTOR shall provide for any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary when elevated blood lead levels are identified in children. Such services would include both MCO case management services and a one (1) time investigation to determine the source of lead.

2.7.5.4.7.3 The CONTRACTOR is responsible for the primary environmental lead investigation—commonly called a "lead inspection"—for children when elevated blood levels suggest a need for such an investigation.

2.7.5.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

2.7.5.4.7.5 CONTRACTOR reimbursement for the primary environmental investigations is limited to the items specified in Part 5 of the State Medicaid Manual. These items include the health professional's time and activities during the on-site investigation of the child's primary residence. They do not include testing of environmental substances such as water, paint, or soil.

2.7.5.4.8 *Services Chart*

Pursuant to federal and state requirements, TennCare enrollees under the age of 21 are eligible for all services listed in Section 1905(a) of the Social Security Act. These services, and the entity responsible for providing them to TennCare enrollees under the age of 21, are listed below. Notwithstanding any other provision of this Agreement, the CONTRACTOR shall provide all services for which "MCO" is identified as the responsible entity to members under the age of 21. All services, other than TENNderCare screens and interperiodic screens, must be medically necessary in order to be covered by the CONTRACTOR. The CONTRACTOR shall provide all medically necessary TENNderCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by a contract provider.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)		MCO	
(2)(A) Outpatient hospital services		MCO	
(2)(B) Rural health clinic services (RHCs)		MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)		MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services		MCO	

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(4)(A) Nursing facility services for individuals age 21 and older			Not applicable for TENNderCare
(4)(B) EPSDT services		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.2; PBM for pharmacy services as described except as in Section 2.6.1.2	
(4)(C) Family planning services and supplies		MCO; PBM for pharmacy services except as described in Section 2.6.1.2	
(5)(A) Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility		MCO	
(5)(B) Medical and surgical services furnished by a dentist		DBM except as described in Section 2.6.1.2	
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law		MCO	See Item (13)
(7) Home health care services		MCO	
(8) Private duty nursing services		MCO	
(9) Clinic services		MCO	
(10) Dental services		DBM except as described in Section 2.6.1.2	
(11) Physical therapy and related services		MCO	

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses		MCO; PBM for pharmacy services except as described in Section 2.6.1.2; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.2; PBM for pharmacy services except as described in Section 2.6.1.2	The following are considered practitioners of the healing arts in Tennessee law:[1] • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel

[1] This list was provided by the Tennessee Department of Health.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			• Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			• Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases			Not applicable for TENNderCare
(15) Services in an intermediate care facility for the mentally retarded		TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21		MCO	
(17) Services furnished by a nurse-midwife		MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care		MCO	
(19) Case management services		MCO	
(20) Respiratory care services		MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner		MCO	The MCOs are not required to contract with PNPs or CFNPs if the services are available through other contract providers.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(22) Home and community care for functionally disabled elderly individuals			Not applicable for TENNderCare
(23) Community supported living arrangements services			Not applicable for TENNderCare
(24) Personal care services		MCO	
(25) Primary care case management services			Not applicable
(26) Services furnished under a PACE program			Not applicable for TENNderCare
(27) Any other medical care, and any other type of remedial care recognized under state law.		MCO for physical and behavioral health services; DBM for dental services except as described in Section 2.6.1.2; PBM for pharmacy services except as described in Section 2.6.1.2	See Item (13)

2.7.5.4.8.1 **Note 1:** "Targeted case management services," which are listed under Section 1915(g)(1), are **not TENNderCare services** except to the extent that the definition in Section 1915(g)(2) is used with Item (19) above.

2.7.5.4.8.2 **Note 2:** "Psychiatric residential treatment facility" is not listed in Social Security Act Section 1905(a). It is, however, defined in 42 CFR 483.352 as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age twenty-one (21), in an inpatient setting."

2.7.5.4.8.3 **Note 3:** "Rehabilitative" services are differentiated from "habilitative" services in federal law. "Rehabilitative" services, which are TENNderCare services, are defined in 42 CFR 440.130(d) as services designed "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." "Habilitative" services, which are **not TENNderCare services**, are defined in Section 1915(c)(5) as services designed "to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

2.7.5.4.8.4 **Note 4:** Certain services are covered under a Home and Community Based waiver but are **not TENNderCare services** because they are not listed in the Social Security Act Section 1905(a). These services include habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)

2.7.5.4.8.5 **Note 5:** Certain services are not coverable even under a Home and Community Based waiver and are **not TENNderCare services**. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

2.7.5.5 Children with Special Health Care Needs

Children with special health care needs are those children who are in the custody of DCS. As provided in Section 2.4.4.4, TennCare enrollees who are in the custody of DCS will be enrolled in TennCare Select.

2.7.6 **Advance Directives**

2.7.6.1 The CONTRACTOR shall maintain written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives, including but not limited to 42 CFR 422.128, 438.6 and 489 Subpart I; TCA 32-11-101 *et seq.*, 34-6-201 *et seq.*, and 68-11-201 through 68-11-224; and any requirements as stipulated by the member. Any written information provided by the CONTRACTOR must reflect changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change.

2.7.6.2 The CONTRACTOR shall provide its policies and procedures to all members eighteen (18) years of age and older and shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members and/or contract providers are responsible for providing this education.

2.7.6.3 The CONTRACTOR shall educate its staff about its policies and procedures on advance directives, situations in which advance directives may be of benefit to members, and their responsibility to educate members about this tool and assist them to make use of it.

2.7.6.4 The CONTRACTOR, for behavioral health services, shall provide its policies and procedures to all members sixteen (16) years of age and older and shall educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment under TCA Title 33, Chapter 6, Part 10. The CONTRACTOR shall specifically designate staff members and/or providers responsible for providing this education.

2.7.7 **Sterilizations, Hysterectomies and Abortions**

2.7.7.1 The CONTRACTOR shall cover sterilizations, hysterectomies and abortions 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.

2.7.7.2 Sterilizations

Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing. The CONTRACTOR shall cover sterilizations only if the following requirements are met:

2.7.7.2.1 The member has given informed consent not less than thirty (30) full calendar days (or not less than seventy-two (72) hours in the case of premature delivery or emergency abdominal surgery) but not more than one-hundred eighty (180) calendar days before the date of the sterilization;

2.7.7.2.2 The member is at least twenty-one (21) years old at the time consent is obtained;

2.7.7.2.3 The member is mentally competent;

2.7.7.2.4 The member is not institutionalized; i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed; and

2.7.7.2.5 The member has voluntarily given informed consent on the approved "STERILIZATION CONSENT FORM" which is available on TENNCARE's web site. The form shall be available in English and Spanish, and the CONTRACTOR shall provide assistance in completing the form when an alternative form of communication is necessary.

2.7.7.3 Hysterectomies

2.7.7.3.1 The CONTRACTOR shall cover hysterectomies only if the following requirements are met:

2.7.7.3.1.1 The hysterectomy is medically necessary;

2.7.7.3.1.2 The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing; and

2.7.7.3.1.3 The member or her authorized representative, if any, has signed and dated a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form which is available on TENNCARE's web site, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary.

2.7.7.3.2 The CONTRACTOR shall not cover hysterectomies under the following circumstances:

2.7.7.3.2.1 If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing;

2.7.7.3.2.2 If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing; or

2.7.7.3.2.3 It is performed for the purpose of cancer prophylaxis.

2.7.7.4 Abortions

2.7.7.4.1 The CONTRACTOR shall cover abortions and services associated with the abortion procedure only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

2.7.7.4.2 The CONTRACTOR shall ensure that a "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" form, which is available on TENNCARE's web site, is completed.

2.8 DISEASE MANAGEMENT

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate a disease management (DM) program for each of the following conditions:

2.8.1.1.1 Maternity care management, in particular high-risk obstetrics;

2.8.1.1.2 Diabetes;

2.8.1.1.3 Congestive heart failure;

2.8.1.1.4 Asthma;

2.8.1.1.5 Coronary artery disease;

2.8.1.1.6 Chronic-obstructive pulmonary disease;

2.8.1.1.7 Bipolar disorder;

2.8.1.1.8 Major depression; and

2.8.1.1.9 Schizophrenia.

2.8.1.2 Each DM program must utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care. For the conditions listed in 2.8.1.1 through 2.8.1.6, the guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.

2.8.1.3 The DM programs must emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

2.8.1.4 The CONTRACTOR shall develop and maintain DM program policies and procedures. These policies and procedures must include, for each of the conditions listed above, the following:

2.8.1.4.1 The definition of the target population;

2.8.1.4.2 Member identification strategies;

2.8.1.4.3 The guidelines;

2.8.1.4.4 Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;

2.8.1.4.5 Program content;

2.8.1.4.6 Methods for informing and educating members;

2.8.1.4.7 Methods for informing and educating providers; and

2.8.1.4.8 Program evaluation.

2.8.1.5 As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

2.8.2 Member Identification Strategies

2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

2.8.2.1.1 Members who have reached the service threshold for inpatient hospital services (see Section 2.6.1.3); and

2.8.2.1.2 Members who have reached the service threshold for non-inpatient hospital services (see Section 2.6.1.3) and could potentially benefit from enrollment in a disease management program.

2.8.2.1.3 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

2.8.2.2 The CONTRACTOR shall operate its disease management programs using an "opt out" methodology, meaning that disease management services will be provided to eligible members unless they specifically ask to be excluded.

2.8.3 Stratification

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.

2.8.4 Program Content

Each DM program shall include the development of treatment plans that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues.

2.8.5 Informing and Educating Members

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

2.8.5.1 Are proactive and effective partners in their care;

2.8.5.2 Understand the appropriate use of resources needed for their care;

2.8.5.3 Identify precipitating factors and appropriate responses before they require more acute intervention; and

2.8.5.4 Are compliant and cooperative with the recommended treatment plan.

2.8.6 Informing and Educating Providers

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning

how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

2.8.7 **Program Evaluation**

2.8.7.1 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include:

2.8.7.1.1 Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;

2.8.7.1.2 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.1.3 Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the maternity care management program;

2.8.7.1.4 Appropriate HEDIS measures;

2.8.7.1.5 The active participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;

2.8.7.1.6 Cost savings;

2.8.7.1.7 Member adherence to treatment plans; and

2.8.7.1.8 Provider adherence to the guidelines.

2.8.7.2 The CONTRACTOR shall report on DM activities as required in Section 2.30.5.

2.8.8 **Obesity Disease Management**

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.5). This DM program shall, at a minimum, fulfill all requirements related to the TennCare Partnership with Weight Watchers program. This means that, at a minimum, the CONTRACTOR shall have provider agreements with the appropriate Weight Watchers regional center(s); educate its contract providers about the program to ensure they make appropriate referrals for members; and process claims according to the requirements in Section 2.22. The CONTRACTOR is encouraged to undertake additional obesity disease management activities as cost effective alternative services pursuant to Section 2.6.5.

2.9 SERVICE COORDINATION

2.9.1 **General**

2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility.

2.9.1.2 The CONTRACTOR shall:

2.9.1.2.1 Coordinate care between PCPs and specialists;

2.9.1.2.2 Perform reasonable preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;

2.9.1.2.3 Document authorized referrals in its utilization management system;

2.9.1.2.4 Monitor members with ongoing medical or behavioral health conditions;

2.9.1.2.5 Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home;

2.9.1.2.6 Maintain and operate a formalized hospital and/or institutional discharge planning program;

2.9.1.2.7 Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;

2.9.1.2.8 Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member; and

2.9.1.2.9 Authorize services provided by non-contract providers, as required in this Agreement (see, e.g., Section 2.13).

2.9.2 **Transition of New Members**

2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CONTRACTOR must provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) calendar days however the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

2.9.2.3 In the event an enrollee entering the CONTRACTOR's MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period.

2.9.2.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.7 and in Attachment II of this Agreement.

2.9.2.5 The CONTRACTOR shall develop and maintain policies and procedures regarding the transition of new members.

2.9.3 **Transition of Care**

2.9.3.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions in transitioning to another provider when their current provider has terminated participation with the CONTRACTOR. The CONTRACTOR must provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption of care, whichever is less. The CONTRACTOR shall allow continued access to the provider through the postpartum period for members in their second or third trimester of pregnancy.

2.9.3.2 The CONTRACTOR shall actively assist members in transitioning to another provider when there are changes in providers. The CONTRACTOR shall have transition policies that, at a minimum, include the following:

2.9.3.2.1 A schedule which ensures transfer does not create a lapse in service;

2.9.3.2.2 A mechanism for timely information exchange (including transfer of the member record);

2.9.3.2.3 A mechanism for assuring confidentiality;

2.9.3.2.4 A mechanism for allowing a member to request and be granted a change of provider;

2.9.3.2.5 An appropriate schedule as approved by the State for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.

2.9.3.2.6 Specific transition language on the following special populations:

2.9.3.2.6.1 Children who are SED;

2.9.3.2.6.2 Adults who are SPMI;

2.9.3.2.6.3 Persons who have addictive disorders;

2.9.3.2.6.4 Persons who have co-occurring disorders of both mental health and alcohol and/or drug abuse disorders; and

2.9.3.2.6.5 Persons with behavioral health conditions who also have a developmental disorder (dually diagnosed). These members shall be allowed to remain with their providers of the services listed below for the minimum time frames set out below as long as the services continue to be medically necessary. The CONTRACTOR may shorten these transition time frames only when the provider of services is no longer available to serve the member or when a change in providers is agreed to in writing by the member.

2.9.3.2.6.5.1 Mental health case management: three (3) months;

2.9.3.2.6.5.2 Psychiatrist: three (3) months;

2.9.3.2.6.5.3 Outpatient behavioral health therapy: three (3) months;

2.9.3.2.6.5.4 Psychosocial rehabilitation and supported employment: three (3) months; and

2.9.3.2.6.5.5 Psychiatric inpatient or residential treatment and supportive housing: six (6) months.

2.9.4 **MCO Case Management**

2.9.4.1 The CONTRACTOR shall maintain an MCO case management program that includes the following components:

2.9.4.1.1 A systematic approach to identify eligible members;

2.9.4.1.2 Assessment of member needs;

2.9.4.1.3 Development of an individualized plan of care;

2.9.4.1.4 Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and

2.9.4.1.5 Monitoring of outcomes.

2.9.4.2 The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:

2.9.4.2.1 Members who have reached the service threshold for inpatient hospital services (see Section 2.6.1.3);

2.9.4.2.2 Members who have reached the service threshold for non-inpatient hospital services and could potentially benefit from enrollment in MCO case management; and

2.9.4.2.3 Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions.

2.9.4.3 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program.

2.9.4.4 Eligible members must be offered MCO case management services. However, member participation shall be voluntary.

2.9.4.5 The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP when a member has been assigned to the MCO case management program.

2.9.4.6 The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM (see Section 2.9.7), to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has reached a service threshold (see Section 2.6.1.3).

2.9.5 Coordination and Collaboration Between Physical Health and Behavioral Health

2.9.5.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health and behavioral health services. The CONTRACTOR shall ensure communication and coordination between PCPs and medical specialists. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical and behavioral health services and ensuring collaboration between physical health and behavioral health providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical and behavioral health providers, exchange of information, confidentiality, assessment, treatment plan development, collaboration, MCO case management and disease management, provider training, and monitoring implementation and outcomes.

2.9.5.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding, at a minimum, the items identified in Section 2.9.5.1 as well as prior authorization,

claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section 2.26 of this Agreement.

2.9.5.3 Screening for Behavioral Health Needs

2.9.5.3.1 The CONTRACTOR shall ensure that the need for behavioral health services is systematically identified by and addressed by the member's PCP at the earliest possible time following initial enrollment of the member in the CONTRACTOR's MCO or after the onset of a condition requiring mental health and/or substance abuse treatment.

2.9.5.3.2 The CONTRACTOR shall encourage PCPs and other providers to use a screening tool prior approved by the State as well as other mechanisms to facilitate early identification of behavioral health needs.

2.9.5.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly members with SED/SPMI are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information.

2.9.5.5 Referrals to PCPs

The CONTRACTOR shall ensure that members with both physical health and behavioral health needs are appropriately referred to their PCPs for treatment of their physical health needs. The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need physical health services. The CONTRACTOR shall develop a referral process to be used by its providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health provider.

2.9.5.6 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services.

2.9.5.7 MCO Case Management and Disease Management

The CONTRACTOR shall use its MCO case management and disease management programs (see Sections 2.9.4 and 2.8) to support the continuity and coordination of covered physical and behavioral health services and the collaboration between physical health and behavioral health providers.

2.9.5.8 Monitoring

The CONTRACTOR shall evaluate and monitor the effectiveness of its policies and procedures regarding the continuity and coordination of covered physical and behavioral health services and collaboration between physical and behavioral health providers. This shall include, but not be limited to, an assessment of the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; an evaluation of the appropriateness of psychopharmacological medication; and analysis of data regarding access to appropriate services. Based on these monitoring activities, the CONTRACTOR shall develop and implement interventions to improve continuity, coordination, and collaboration for physical and behavioral health services.

2.9.6 **Coordination and Collaboration Among Behavioral Health Providers**

2.9.6.1 The CONTRACTOR shall ensure communication and coordination between mental health providers and substance abuse providers, including:

2.9.6.1.1 Assignment of a responsible party to ensure communication and coordination occur;

2.9.6.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers;

2.9.6.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers;

2.9.6.1.4 Description of how treatment plans will be coordinated between behavioral health service providers; and

2.9.6.1.5 Assessment of cross training of behavioral health providers: mental health providers being trained on substance abuse issues and substance abuse providers being trained on mental health issues.

2.9.6.2 The CONTRACTOR shall ensure coordination between the children and adolescent service delivery system as they transition into the adult mental health service delivery system, through such activities as communicating treatment plans and exchange of information.

2.9.6.3 The CONTRACTOR shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

2.9.6.3.1 The outpatient provider must be involved in the admissions process when possible; if the outpatient provider is not involved, the outpatient provider must be notified promptly of the member’s hospital admission;

2.9.6.3.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan in which the member has participated (an outpatient visit must be scheduled before discharge, which ensures access to proper provider/medication follow-up; also, an appropriate placement or housing site must be secured prior to discharge);

2.9.6.3.3 An evaluation must be performed prior to discharge to determine if mental health case management services are medically necessary. Once deemed medically necessary, the mental health case manager must be involved in discharge planning; if there is no mental health case manager, then the outpatient provider must be involved; and

2.9.6.3.4 A procedure to ensure continuity of care regarding medication must be developed and implemented.

2.9.6.4 The CONTRACTOR shall identify and develop community alternatives to inpatient hospitalization for those members who are receiving inpatient psychiatric facility services who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the CONTRACTOR does not provide appropriate community alternatives, the CONTRACTOR shall remain financially responsible for the continued inpatient care of these individuals.

2.9.6.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section 2.9.6.3.2.

2.9.7 **Coordination of Pharmacy Services**

2.9.7.1 Except as provided in Section 2.6.1.2, the CONTRACTOR is not responsible for the provision and payment of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.

2.9.7.2 The CONTRACTOR shall accept and maintain prescription drug data from TENNCARE or its PBM.

2.9.7.3 The CONTRACTOR shall monitor and manage members by, at a minimum, conducting the activities as described below:

2.9.7.3.1 Analyzing prescription drug data and/or reports provided by the PBM to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to the MCO case management and/or disease management programs as appropriate;

2.9.7.3.2 Analyzing prescription drug data and/or reports provided by the PBM to identify potential pharmacy lock-in candidates and referring them to TENNCARE; and

2.9.7.3.3 Regularly providing information to members about appropriate prescription drug usage. At a minimum, this information shall be included in the Member Handbook and in at least two (2) quarterly member newsletters within a twelve (12) month period.

2.9.7.4 The CONTRACTOR shall monitor and manage providers' prescription patterns by, at a minimum, conducting the activities described below:

2.9.7.4.1 Collaborating with the PBM to educate the MCO's contract providers regarding compliance with the State's preferred drug list (PDL) and appropriate prescribing practices; and

2.9.7.4.2 Intervening with contract providers whose prescribing practices appear to be operating outside industry or peer norms as defined by TENNCARE, are non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns, and/or who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices among the identified contract providers, as appropriate. Interventions shall be personal and one-on-one.

2.9.7.5 At any time, upon request from TENNCARE, the CONTRACTOR shall provide assistance in educating, monitoring and intervening with providers. For example, TENNCARE may require assistance in monitoring and intervening with providers regarding prescribing patterns for narcotics.

2.9.8 **Coordination of Dental Benefits**

2.9.8.1 General

2.9.8.1.1 The CONTRACTOR is not responsible for the provision and payment of dental benefits; TENNCARE contracts with a dental benefits manager (DBM) to provide these services.

2.9.8.1.2 As provided in Section 2.6.1.2, the CONTRACTOR is responsible for transportation to and from dental services as well as the facility, medical and anesthesia services related to medically necessary and approved dental services that are not provided by a dentist or in a dentist's office.

2.9.8.1.3 The CONTRACTOR may require prior authorization for transportation, facility, anesthesia, and/or medical services related to the dental service; however, the CONTRACTOR may waive authorization of said services based on authorization of the dental services by the dental benefits manager.

2.9.8.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

2.9.8.2.1 Means for referral that ensures immediate access for emergency care and provision of urgent and routine care according to TennCare guidelines for specialty care (see Attachment III);

2.9.8.2.2 Means for the transfer of information (to include items before and after the visit);

2.9.8.2.3 Maintenance of confidentiality;

2.9.8.2.4 Resolving disputes related to prior authorizations and claims and payment issues; and

2.9.8.2.5 Cooperation with the DBM regarding training activities provided by the DBM.

2.9.8.3 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM. However, the CONTRACTOR shall provide coordination assistance and shall be responsible for communicating the DBM provider services and/or claim coordinator contact information to all of its contract providers. With respect to specific member issues, the CONTRACTOR shall work with the DBM coordinator towards a resolution. Should systemic issues arise, the CONTRACTOR shall meet and resolve the issues with the DBM. In the event that such issues cannot be resolved, the MCO and the DBM shall meet with TENNCARE to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) calendar days from referral to TENNCARE.

2.9.8.4 Resolution of Requests for Prior Authorization

2.9.8.4.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare enrollee. The CONTRACTOR shall require that its care coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for prior authorization that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM with a list of its care coordinators and telephone number(s) at which each care coordinator may be contacted. When the CONTRACTOR receives a request for prior authorization from a provider for a member and the CONTRACTOR believes the service is the responsibility of the DBM, the CONTRACTOR's care coordinator shall contact the DBM's care coordinator by the next business day after receiving the request for prior authorization. The care coordinator shall also contact the member and/or member's provider. For routine requests contact to the member or member's provider shall be made within fourteen (14) days or less of the provider's request for prior authorization and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations. For urgent requests, contact shall be made immediately after receiving the request for prior authorization.

2.9.8.4.2 The CONTRACTOR shall assign staff members to serve on a coordination committee with DBM staff members. This committee shall be responsible for addressing all issues of dental care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the

terms of this Agreement. The CONTRACTOR and the DBM will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting prior authorization of a service. In the event the CONTRACTOR and the DBM cannot agree within ten (10) calendar days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for prior authorization and payment to the contract provider within the time frames designated by TENNCARE. The CONTRACTOR and the DBM are responsible for enforcing hold harmless protection for the member. The CONTRACTOR shall ensure that any response to a request for authorization shall not exceed fourteen (14) calendar days and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations.

2.9.8.5 Claim Resolution Processes

2.9.8.5.1 The CONTRACTOR shall designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to also designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM and TennCare, with a list of its claims coordinators and telephone number(s) at which each claims coordinator may be contacted.

2.9.8.5.2 When the CONTRACTOR receives a disputed claim for payment from a provider for a member and believes care is the responsibility of the DBM, the CONTRACTOR's claims coordinators shall contact the DBM's claims coordinators within four (4) calendar days of receiving such claim for payment. If the CONTRACTOR's claims coordinator is unable to reach agreement with the DBM's claims coordinators on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee (described below) for review.

2.9.8.5.3 The CONTRACTOR shall assign claims coordinators and other representatives, as needed, to a joint CONTRACTOR/DBM Claims Coordination Committee. The number of members serving on the Claims Coordination Committee shall be determined within ten (10) calendar days of the execution of this Agreement by the mutual agreement of the DBM and MCO. The CONTRACTOR shall, at a minimum, assign two (2) representatives to the committee. The make-up of the committee may be revisited from time to time during the term of this Agreement. The Claims Coordination Committee shall review any disputes and negotiate responsibility between the CONTRACTOR and the DBM. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party shall reimburse and abide by the prior decisions of that party. Reimbursement shall be made within ten (10) calendar days of the Claims Coordination Committee's decision.

2.9.8.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to both the

CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s) as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.

2.9.8.5.5 If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days of the meeting, submit a Request for Resolution of the dispute to the State or the State's designee for a decision on responsibility.

2.9.8.5.6 The process before the submission of a Request for Resolution, as described above, shall be completed within thirty (30) calendar days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) calendar days of receiving the claim for payment, the MCO and the DBM will be responsible for enforcing hold harmless protections for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider in accordance with the requirements of the MCO's or DBM's respective Agreement/contract with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

2.9.8.5.7 The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable Agreement/contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution.

2.9.8.5.8 The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information ("Decision"). The Decision may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The Decision shall be determined solely by the State, or its designee, based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars ($1,000), for each Request for Resolution. The amount of the DBM's or MCO's payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party's payment responsibility as described in this Section, Section 2.9.8.5.8, within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

2.9.8.6 Denial, Delay, Reduction, Termination or Suspension

The CONTRACTOR agrees that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency services specified in this Agreement.

2.9.8.7 Emergencies

Prior authorization shall not be required for emergency services prior to stabilization.

2.9.8.8 Claims Processing Requirements

All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements/contracts with the State of Tennessee.

2.9.8.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq*. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section 2.9.8.

2.9.8.10 Duties and Obligations

The existence of any dispute under this Agreement shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective obligations, including their obligations established in their respective Agreements/contracts with the State pending resolution of the dispute under this Section, Section 2.9.8.10. In accordance with TCA 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.8.11 Confidentiality

2.9.8.11.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, to cooperate with the State to develop confidentiality guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards shall apply to both DBM's and MCO's providers and staff. If the CONTRACTOR or DBM believes that the standards require updating, or operational changes are needed to enforce the standards, the CONTRACTOR shall meet with the DBM to resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

2.9.8.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22, Section 4.33 of this Agreement, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those requirements or to TENNCARE, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.8.12 Access to Service

The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to establish methods of referral which ensure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2.9.9 **Coordination with Medicare**

2.9.9.1 The CONTRACTOR is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

2.9.9.2 The CONTRACTOR shall ensure that services covered and provided pursuant to this Agreement are delivered without charge to members who are dually eligible for Medicare and Medicaid services.

2.9.9.3 The CONTRACTOR shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

.

2.9.10 **Institutional Services and Alternatives to Institutional Services**

2.9.10.1 For members enrolled in the long-term care program, the CONTRACTOR is not responsible for long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to these institutional services. These services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

2.9.10.2 The CONTRACTOR is responsible for covered services for members residing in long-term care institutions or enrolled in a HCBS waiver. The CONTRACTOR is responsible for those TennCare covered benefits that are not included in the per diem reimbursement for institutional services (e.g., prosthetics, some items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation) or are not provided through the HCBS waiver. Covered benefits that are not provided by TENNCARE through the long-term care institution or HCBS waiver shall be the responsibility of the CONTRACTOR.

2.9.10.3 The CONTRACTOR shall coordinate the provision of covered services with institutional and HCBS waiver providers to minimize disruption and duplication of services.

2.9.10.4 The CONTRACTOR shall use its best efforts to increase the use of HCBS waivers as an alternative to long-term care institutions. This should include educating members entering or recently admitted to a long-term care institution, as well as their providers, about available HCBS waivers and coordinating with the Commission on Aging and Disability and TennCare Bureau, Long Term Care Division, as needed and as requested by TENNCARE.

2.9.11 **Inter-Agency Coordination**

The CONTRACTOR shall coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with:

2.9.11.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) and Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care;

2.9.11.2 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;

2.9.11.3 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;

2.9.11.4 The Division of Mental Retardation Services (DMRS), for the purposes of interfacing with and assuring continuity of care;

2.9.11.5 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.11.6 Commission on Aging and Disability and TennCare Bureau, Long Term Care Division for the purposes of coordinating care for members requiring long-term care services; and

2.9.11.7 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

2.10 SERVICES NOT COVERED

Except as authorized pursuant to Section 2.6.5 of this Agreement, the CONTRACTOR shall not pay for non-covered services as described in TennCare rules and regulations.

2.11 PROVIDER NETWORK

2.11.1 General Provisions

2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section 2.6.1 of this Agreement. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the Terms and Conditions for Access which is part of the TennCare waiver and is contained herein as Attachment III, the Specialty Network Standards in Attachment IV, the Access and Availability for Behavioral Health Services in Attachment V and the requirements herein. These minimum requirements are not intended to release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.

2.11.1.2 The CONTRACTOR may provide covered services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered services to the members in exchange for payment by the CONTRACTOR for services rendered.

2.11.1.3 Should the CONTRACTOR elect to contract with providers (as opposed to using staff providers) and develop a network for the provision of covered services, the CONTRACTOR shall:

2.11.1.3.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program;

2.11.1.3.2 Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Agreement; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;

2.11.1.3.3 Have in place, written policies and procedures for the selection and retention of providers. These policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;

2.11.1.3.4 Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination;

2.11.1.3.5 Give affected providers written notice if it declines to include individual or groups of providers in its network; and

2.11.1.3.6 Maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section 2.12 of this Agreement.

2.11.1.4 Section 2.11.1.3 shall not be construed to:

2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Agreement;

2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; or

2.11.1.4.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

2.11.1.5 The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

2.11.1.5.1 The member's health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered;

2.11.1.5.2 Any information the member needs in order to decide among all relevant treatment options;

2.11.1.5.3 The risks, benefits, and consequences of treatment or non-treatment; or

2.11.1.5.4 The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has obtained a Medicaid provider number from TENNCARE.

2.11.1.7 If a member requests a provider located outside the access standards, and the CONTRACTOR has an appropriate provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall not be responsible for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider.

2.11.1.8 If the CONTRACTOR is unable to meet the access standards for a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.

2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section 2.9.3.

2.11.1.10 The CONTRACTOR shall monitor provider compliance with applicable access requirements, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.7.2.

2.11.1.11 The CONTRACTOR shall use its best efforts to contract with providers to whom the CONTRACTOR routinely refers members.

2.11.1.12 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section 2.30.7.

2.11.2 **Primary Care Providers (PCPs)**

2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an identified PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member.

2.11.2.2 The CONTRACTOR shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and behavioral health needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the Terms and Conditions for Access provided in Attachment III.

2.11.2.3 To the extent feasible and appropriate, the CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.

2.11.2.4 The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP as defined in Section 1.

2.11.2.5 If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.

2.11.2.6 The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR must include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.

2.11.2.7 If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR must allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2.11.3 **Specialty Service Providers**

2.11.3.1 Essential Hospital Services and Centers of Excellence

2.11.3.1.1 The CONTRACTOR shall demonstrate sufficient access to essential hospital services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:

2.11.3.1.1.1 Neonatal services;

2.11.3.1.1.2 Perinatal services;

2.11.3.1.1.3 Pediatric services;

2.11.3.1.1.4 Trauma services; and

2.11.3.1.1.5 Burn services.

2.11.3.1.2 The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH.

2.11.3.1.3 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for Behavioral Health located within the Grand Region(s) served by the CONTRACTOR.

2.11.3.2 Physician Specialists

2.11.3.2.1 The CONTRACTOR shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

2.11.3.2.1.1 The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and

2.11.3.2.1.2 The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, IV, and V.

2.11.3.3 TENNCARE Monitoring

2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2.30.7.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

2.11.3.3.2 TENNCARE will require a corrective action plan from the CONTRACTOR when:

2.11.3.3.2.1 Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;

2.11.3.3.2.2 Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or

2.11.3.3.2.3 The member to provider ratio exceeds that listed in Attachment IV.

2.11.3.3.3 TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:

2.11.3.3.3.1 The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;

2.11.3.3.3.2 A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;

2.11.3.3.3.3 For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;

2.11.3.3.3.4 A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;

2.11.3.3.3.5 Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;

2.11.3.3.3.6 Documentation of how these arrangements are communicated to the member; and

2.11.3.3.3.7 Documentation of how these arrangements are communicated to the PCPs.

2.11.3.4 Weight Watchers

The CONTRACTOR shall include in its network the Weight Watchers regional center in the Grand Region(s) in which the CONTRACTOR operates.

2.11.4 **Special Conditions for Prenatal Care Providers**

2.11.4.1 The CONTRACTOR shall have a sufficient number of contract providers who accept members in accordance with TennCare access standards in Attachment III so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.

2.11.4.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections 2.7.4.2. and 2.11.4).

2.11.5 **Special Conditions for Behavioral Health Services**

2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity.

2.11.5.2 The CONTRACTOR shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents with a co-occurring mental health and substance abuse disorder.

2.11.5.3 The CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by TENNCARE unless the State approves the use of other crisis service providers.

2.11.6 **Safety Net Providers**

2.11.6.1 Federally Qualified Health Centers (FQHCs)

2.11.6.1.1 The CONTRACTOR is encouraged to contract with FQHCs and other safety net providers (e.g., rural health clinics) in the CONTRACTOR's service area to the extent possible and practical. Where FQHCs are not utilized, the CONTRACTOR must demonstrate to DHHS, the Tennessee DHS and TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with FQHCs.

2.11.6.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section 2.30.7.6 of this Agreement.

2.11.6.2 Community Mental Health Agencies (CMHAs)

The CONTRACTOR is encouraged to contract with CMHAs and other behavioral health safety net providers in the CONTRACTOR's service area to the extent possible and practical. Where CMHAs are not utilized, the CONTRACTOR must demonstrate that both adequate capacity and an appropriate range of services for all populations, but in particular SPMI/SED populations, exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with CMHAs.

2.11.6.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in the Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.4.

2.11.7 **Credentialing and Other Certification**

2.11.7.1 Credentialing of Contract Providers

2.11.7.1.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.7.1.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.7.2 Credentialing of Non-Contract Providers

2.11.7.2.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

2.11.7.2.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.7.3 Credentialing of Behavioral Health Entities

2.11.7.3.1 The CONTRACTOR shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.

2.11.7.3.2 When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the CONTRACTOR to ensure, based on applicable state licensure rules and/or programs standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

2.11.7.4 Compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with

certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

2.11.7.5 Weight Watchers Centers

The CONTRACTOR is not required to credential the Weight Watchers centers(s) referenced in Section 2.11.3.4 of this Agreement.

2.11.8 **Network Notice Requirements**

2.11.8.1 Member Notification

All member notices required shall be written using the appropriate notice template provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.11.8.1.1 *Change in PCP*

The CONTRACTOR shall immediately provide written notice to a member when the CONTRACTOR changes the member's PCP. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances necessitating a PCP change.

2.11.8.1.2 *PCP Termination*

If a PCP ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as their PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.3 *Providers Providing Ongoing Treatment Termination*

If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the

effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been patients of the non-PCP provider. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

2.11.8.1.5 *Network Deficiency*

Upon notification from TENNCARE that a corrective action plan designed to remedy a network deficiency has not been accepted, the CONTRACTOR shall immediately provide written notice to members living in the affected area of a provider shortage in the CONTRACTOR's network.

2.11.8.2 <u>TENNCARE Notification</u>

2.11.8.2.1 *Subcontractor Termination*

When a subcontract that relates to the provision of services to members or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI. Said notices shall include, at a minimum: a CONTRACTOR's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide a transition plan to TENNCARE within fifteen (15) calendar days, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition and how continuity of care will be maintained for the members.

2.11.8.2.2 *Hospital Termination*

Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the hospital or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the TENNCARE no less than thirty (30) calendar days prior to the effective date of the termination.

2.11.8.2.3 *Other Provider Terminations*

2.11.8.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit a copy of one of the actual member notices mailed as well as an electronic listing identifying each member to whom a notice was sent within five

(5) business days of the date the member notice was sent as required in Section 2.11.8.1. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR.

2.11.8.2.3.2 If termination of the CONTRACTOR's provider agreement with any PCP or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2.11 and Attachments III, IV and V, such termination shall be reported by the CONTRACTOR in writing to TENNCARE, in the standard format provided by TENNCARE to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

2.12 PROVIDER AGREEMENTS

2.12.1 Provider agreements, as defined in Section 1 of this Agreement, shall be administered in accordance with this Agreement and must contain all of the items listed in this Section 2.12.

2.12.2 All template provider agreements and revisions thereto must be approved in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.

2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.

2.12.4 All single case agreements shall be reported to TENNCARE in accordance with Section 2.30.8; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears single case agreements are being used to circumvent the provider agreement review and approval process.

2.12.5 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement.

2.12.6 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.

2.12.7 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, at a minimum, meet the following requirements:

2.12.7.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;

2.12.7.2 Specify the effective dates of the provider agreement;

2.12.7.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

2.12.7.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior approval of the CONTRACTOR;

2.12.7.5 Identify the population covered by the provider agreement;

2.12.7.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

2.12.7.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

2.12.7.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;

2.12.7.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;

2.12.7.10 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the provider's agreement with the CONTRACTOR and include definition of unreasonable delay as described in Section 2.7.4.2.3 of this Agreement;

2.12.7.11 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

2.12.7.12 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records must be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary

for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

2.12.7.13 Include a statement that as a condition of participation in TennCare, enrollees shall give TENNCARE, the Office of the Comptroller, and any health oversight agency, such as OIG, MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Comptroller personnel, including, but not limited to, the OIG, the MFCU, the DHHS OIG and the DOJ;

2.12.7.14 Include medical records requirements found in Section 2.24.4 of this Agreement ;

2.12.7.15 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;

2.12.7.16 Provide that TENNCARE, DHHS OIG, Comptroller, OIG, MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, MFCU, DHHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

2.12.7.17 Provide for monitoring, whether announced or unannounced, of services rendered to members;

2.12.7.18 Provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;

2.12.7.19 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;

2.12.7.20 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

2.12.7.21 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

2.12.7.22 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;

2.12.7.23 Provide the name and address of the official payee to whom payment shall be made;

2.12.7.24 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;

2.12.7.25 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;

2.12.7.26 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-226 and Section 2.22.4 of this Agreement;

2.12.7.27 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;

2.12.7.28 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

2.12.7.29 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.7 of this Agreement;

2.12.7.30 Specify the provider's responsibilities regarding third party liability (TPL);

2.12.7.31 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

2.12.7.31.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and

2.12.7.31.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;

2.12.7.32 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;

2.12.7.33 Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

2.12.7.34 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;

2.12.7.35 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms must include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);

2.12.7.36 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4.4 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;

2.12.7.37 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-226(b);

2.12.7.38 Include a conflict of interest clause as stated in Section 4.19 of this Agreement, Gratuities clause as stated in Section 4.23 of this Agreement, and Lobbying clause as stated in Section 4.24 of this Agreement between the CONTRACTOR and TENNCARE;

2.12.7.39 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section 4.31 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved by TENNCARE;

2.12.7.40 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 4.33 of this Agreement;

2.12.7.41 Specify provider actions to improve patient safety and quality;

2.12.7.42 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider will comply with the appeal process, including but not limited to the following:

2.12.7.42.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and

2.12.7.42.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.12.7.43 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;

2.12.7.44 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;

2.12.7.45 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;

2.12.7.46 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.7.5 of this Agreement. All provider agreements must contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or include language to require that these sections be furnished to the provider upon request;

2.12.7.47 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TENNCARE;

2.12.7.48 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

2.12.7.49 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

2.12.7.50 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B; and

2.12.7.51 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.

2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in 2.12.7 above.

2.12.9 The provider agreement with a local health department (see Section 2.11.6.3) must meet the minimum requirements specified above and must also specify for the purpose of TENNderCare screening services: (1) that the local health department agrees to submit encounter data timely to

the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TENNderCare screening services.

2.12.10 The provider agreement for CRG/TPG assessments shall meet the minimum requirements specified above and shall also specify that all CRG/TRG assessments detailed in Section 2.7.2.9 are completed by State-certified raters and that the assessments are completed within the specified time frames. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination, scored only by State-certified trainers.

2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

2.13.1 General

2.13.1.1 The CONTRACTOR must agree to reasonable reimbursement standards to providers for covered services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

2.13.1.2 The CONTRACTOR shall require, as a condition of payment, that the provider (contract or non-contract provider) accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

2.13.1.3 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Agreement, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-226, including but not limited to reconsideration by the CONTRACTOR.

2.13.1.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.7 and in Attachment II of this Agreement.

2.13.1.5 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2.12.7.50 of this Agreement.

2.13.2 Hospice

If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least ninety-five percent (95%) of the prevailing Medicaid NF rate to the hospice provider.

2.13.3 **Behavioral Health Crisis Service Teams**

2.13.3.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services on a monthly basis at a rate to be determined and set by the State. The rate shall be factored into the CONTRACTOR's capitation payments.

2.13.3.2 The CONTRACTOR shall assume financial liability for crisis respite and crisis stabilization services.

2.13.4 **Local Health Departments**

2.13.4.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.6.3 and 2.12.9) for TENNderCare screenings to members under age twenty-one (21) at no less than the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	$80.33
99382 New pt. 1- 4 yrs.	$88.06
99383 New pt. 5 - 11yrs.	$86.60
99384 New pt. 12 - 17yrs.	$95.39
99385 New pt. 18 - 39 yrs.	$93.93
99391 Estab. pt. Up to 1 yr.	$63.04
99392 Estab. pt. 1 - 4 yrs.	$71.55
99393 Estab. pt. 5 - 11yrs.	$70.96
99394 Estab. pt. 12 - 17yrs.	$79.57
99395 Estab. pt. 18 - 39 yrs.	$78.99

2.13.4.2 TENNCARE may conduct an audit of the CONTRACTOR's reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is less than the required minimum reimbursement rate.

2.13.5 **Physician Incentive Plan (PIP)**

2.13.5.1 The CONTRACTOR shall notify and make TENNCARE and TDCI aware of any operations or plans to operate a physician incentive plan (PIP). Prior to implementation of any such plans, the CONTRACTOR shall submit to TDCI any provider agreement templates or subcontracts that involve a PIP for review as a material modification.

2.13.5.2 The CONTRACTOR shall not implement a PIP in the absence of TDCI TennCare Division review and approval.

2.13.5.3 If the CONTRACTOR operates a PIP, the CONTRACTOR shall ensure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.13.5.4 If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR must report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:

2.13.5.4.1 Whether services not furnished by the physician or physician group are covered by the incentive plan;

2.13.5.4.2 The type or types of incentive arrangements, such as, withholds, bonus, capitation;

2.13.5.4.3 The percent of any withhold or bonus the plan uses;

2.13.5.4.4 Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection;

2.13.5.4.5 The patient panel size and, if the plan uses pooling, the pooling method; and

2.13.5.4.6 If the CONTRACTOR is required to conduct enrollee surveys, a summary of the survey results.

2.13.6 **Emergency Services Obtained from Non-Contract Providers**

2.13.6.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section 1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.

2.13.6.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

2.13.6.3 The CONTRACTOR must review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section 1 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section 1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-226, including but not limited to reconsideration by the CONTRACTOR.

2.13.7 **Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown**

2.13.7.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section 2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested (see Section 2.4.4.5). In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

2.13.7.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.8 **Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown**

2.13.8.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.

2.13.8.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.9 **Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider**

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider.

2.13.10 **Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR**

2.13.10.1 With the exception of circumstances described in Section 2.13.9, when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

2.13.10.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary.

2.13.11 **Covered Services Ordered by Medicare Providers for Dual Eligibles**

2.13.11.1 When a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR must pay for the ordered, medically necessary service if it is provided by a contract provider.

2.13.11.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.11.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

2.13.12 **Transition of New Members**

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall not deny payment for the costs of continuation of medically necessary covered services provided by contract or non-contract providers for lack of prior authorization or lack of referral during the required time period for continuation of services. However, if, pursuant to Section 2.9.2.1, the CONTRACTOR requires prior authorization for continuation of services beyond thirty (30) calendar days, the CONTRACTOR may deny payment for care rendered beyond the initial thirty (30) days for lack of prior authorization but may not do so solely on the basis that the provider is a non-contract provider.

2.13.13 **Transition of Care**

In accordance with the requirements in Section 2.9.3.1 of this Agreement, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section 2.9.3.1.

2.13.14 **Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR**

2.13.14.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that has an indirect ownership interest or an ownership or control interest in the CONTRACTOR or the CONTRACTOR's affiliates or the CONTRACTOR's management company than the CONTRACTOR pays to

providers and subcontractors that do not have an indirect ownership interest or an ownership or control interest in the CONTRACTOR, the CONTRACTOR's affiliates or the CONTRACTOR's management company for similar services. The standards and criteria for determining whether a provider or a subcontractor has an indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.14.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be considered non-allowable payments for covered services and shall be excluded from medical expenses reported in the MLR report required in Section 2.30.14.2.1.

2.13.14.3 As provided in Section 2.30.9 of this Agreement, the CONTRACTOR shall submit information on payments to related providers and subcontractors.

2.13.15 **1099 Preparation**

In accordance with federal requirements, the CONTRACTOR shall prepare and submit Internal Revenue Service (IRS) Form 1099s for all providers who are not employees of the CONTRACTOR to whom payment is made

2.14 UTILIZATION MANAGEMENT (UM)

2.14.1 General

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.2 The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to UM procedures.

2.14.1.3 The UM program shall have criteria that:

2.14.1.3.1 Are objective and based on medical and/or behavioral health evidence;

2.14.1.3.2 Are applied based on individual needs;

2.14.1.3.3 Are applied based on an assessment of the local delivery system;

2.14.1.3.4 Involve appropriate practitioners in developing, adopting and reviewing them; and

2.14.1.3.5 Are annually reviewed and up-dated as appropriate.

2.14.1.4 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The

CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease.

2.14.1.5 Except as provided in Section 2.6.1.4, the CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.

2.14.1.6 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

2.14.1.7 The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

2.14.1.8 As part of the provider survey required by Section 2.18.7.2, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.

2.14.1.9 The UM program policies and procedures, the annual evaluation (which includes an analysis of findings and actions taken) and the work plan shall be approved by the CONTRACTOR's oversight committee. These three (3) items shall be submitted to TENNCARE for approval in accordance with Section 2.30.10.1.

2.14.1.10 <u>Inpatient Care</u>

The CONTRACTOR shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs 2.14.1.10.1 through 2.14.1.10.5 below:

2.14.1.10.1 Pre-admission certification process for non-emergency admissions;

2.14.1.10.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;

2.14.1.10.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

2.14.1.10.4 Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and

2.14.1.10.5 Prospective review of same day surgery procedures.

2.14.1.11 Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:

2.14.1.11.1 Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify members with utilization exceeding the threshold defined by TENNCARE in the preceding six (6) month period. The January review shall cover ED utilization during the preceding April through September; the July review shall cover ED utilization during the preceding October through March;

2.14.1.11.2 Enroll members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in MCO case management if appropriate;

2.14.1.11.3 As appropriate, make contact with members whose utilization exceeded the threshold of ED visits defined by TENNCARE in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization; and

2.14.1.11.4 Assess the most likely cause of high utilization and develop an MCO case management plan based on results of the assessment for each member.

2.14.1.12 Hospitalizations and Surgeries

The CONTRACTOR shall comply with any applicable federal and state laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE may conduct special studies to assess the appropriateness of hospital discharges.

2.14.2 **Prior Authorization for Covered Services**

2.14.2.1 General

2.14.2.1.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.1.2 Prior authorization requests shall be reviewed subject to the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request.

2.14.2.2 Notice of Adverse Action Requirements

2.14.2.2.1 The CONTRACTOR shall clearly document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.

2.14.2.2.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.

2.14.2.3 Medical History Information Requirements

2.14.2.3.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating health care provider(s), as needed, for purposes of making medical necessity determinations. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

2.14.2.3.2 Upon request by TENNCARE, the CONTRACTOR shall provide TENNCARE with individualized medical record information from the treating health care provider(s). The CONTRACTOR shall take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable TennCare rules and regulations, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is

decided in favor of the member, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2.14.3 **Referrals**

2.14.3.1 Except as provided in Section 2.14.4, the CONTRACTOR may require members to seek a referral from their PCP prior to accessing non-emergency specialty physical health services.

2.14.3.2 If the CONTRACTOR requires members to obtain PCP referral, the CONTRACTOR may exempt certain services, identified by the CONTRACTOR in the member handbook, from PCP referral.

2.14.3.3 For members determined to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.

2.14.3.4 The CONTRACTOR shall not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

2.14.3.5 Referral Provider Listing

2.14.3.5.1 The CONTRACTOR shall provide all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least thirty (30) calendar days prior to the start date of operations. Thereafter the CONTRACTOR shall mail PCPs an updated version of the listing on a quarterly basis. The CONTRACTOR shall also maintain an updated electronic, web-accessible version of the referral provider listing.

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section 2.17.7.

2.14.3.5.3 As required in Section 2.30.10.7, the CONTRACTOR shall submit to TENNCARE a copy of the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.14.4 **Exceptions to Prior Authorization and/or Referrals**

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section 1) in accordance with 42 CFR 422.113.

2.14.4.2 TENNderCare

The CONTRACTOR shall not require prior authorization or PCP referral for the provision of TENNderCare screening services.

2.14.4.3 Access to Women's Health Specialists

The CONTRACTOR shall allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

2.14.4.4 Behavioral Health Services

The CONTRACTOR shall not require a PCP referral for members to access a behavioral health provider.

2.14.4.5 Transition of New Members

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements. However, as provided in Section 2.9.2.1, in certain circumstances the CONTRACTOR may require prior authorization for continuation of services beyond the initial thirty (30) days.

2.14.5 **PCP Profiling**

The CONTRACTOR shall profile its PCPs. Further, the CONTRACTOR shall investigate the circumstances surrounding PCPs who appear to be operating outside peer norms and will intervene, as appropriate, when utilization or quality of care issues are identified. As part of these profiling activities, the CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back information as requested by TENNCARE. PCP profiling shall include, but not be limited to the following areas:

2.14.5.1 Utilization of Non-Contract Providers

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of services provided by non-contract providers by PCP panel.

2.14.5.2 Specialist Referrals

The CONTRACTOR shall maintain a procedure to identify and evaluate member specialty provider utilization by PCP panel.

2.14.5.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.9.4, members who establish a pattern of accessing emergency room services shall be referred to MCO case management as appropriate for follow-up.

2.14.5.4 Inpatient Admissions

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of inpatient services by PCP panel.

2.14.5.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section 2.9.7 of this Agreement.

2.14.5.6 Advanced Imaging Procedures

The CONTRACTOR shall profile the utilization of advanced imaging procedures by PCP panel. Advanced imaging procedures include: PET Scans; CAT Scans and MRIs.

2.14.5.7 PCP Visits

The CONTRACTOR shall profile the average number of visits per member assigned to each PCP.

2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

2.15.1 Quality Management/Quality Improvement (QM/QI) Program

2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:

2.15.1.1.1 Specifically address behavioral health care;

2.15.1.1.2 Be accountable to the CONTRACTOR's board of directors and executive management team;

2.15.1.1.3 Have substantial involvement of a designated physician and designated behavioral health practitioner;

2.15.1.1.4 Have a QM/QI committee that oversees the QM/QI functions;

2.15.1.1.5 Have an annual work plan;

2.15.1.1.6 Have resources – staffing, data sources and analytical resources – devoted to it; and

2.15.1.1.7 Be evaluated annually and updated as appropriate.

2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.

2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.

2.15.1.4 Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2 **QM/QI Committee**

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include staff and contract providers. Medical and behavioral health staff and contract providers shall be represented on the QM/QI committee. This committee shall recommend policy decisions, analyze and evaluate the results of QM/QI activities, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.

2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

2.15.3 **Performance Improvement Projects (PIPs)**

2.15.3.1 The CONTRACTOR shall perform three (3) clinical PIPs, one (1) in the area of diabetes management, one (1) in the area of maternity management and one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.

2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:

2.15.3.2.1 Rationale for selection as a quality improvement activity;

2.15.3.2.2 Specific population targeted, include sampling methodology if relevant;

2.15.3.2.3 Metrics to determine meaningful improvement and baseline measurement;

2.15.3.2.4 Specific interventions (enrollee and provider);

2.15.3.2.5 Relevant clinical practice guidelines; and

2.15.3.2.6 Date of re-measurement.

2.15.3.3 The CONTRACTOR shall report on PIPs as required in Section 2.30.11.3, Reporting Requirements.

2.15.4 **Performance Indicators**

2.15.4.1 The CONTRACTOR's QM/QI program shall identify benchmarks and set achievable performance goals for the three (3) PIPs required in Section 2.15.3. The three (3) clinical performance indicators that must show meaningful improvement are diabetes management, maternity management and behavioral health. The CONTRACTOR shall identify a relevant HEDIS measure where there is an opportunity to show improvement. The source of the benchmark should be identified, e.g., NCQA's Quality Compass. The CONTRACTOR must demonstrate improvement against the baseline measure as indicated:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point increase
60-74	At least a 5 percentage point increase
75-84	At least a 4 percentage point increase
85-92	At least a 3 percentage point increase
93-96	At least a 2 percentage point increase
97-99	At least a 1 percentage point increase

2.15.4.2 The CONTRACTOR shall report performance indicator results as required in Section 2.30.11.1, Reporting Requirements.

2.15.4.3 The CONTRACTOR's failure to demonstrate meaningful improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2.25.9.

2.15.5 **Clinical Practice Guidelines**

2.15.5.1 The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Two (2) of these guidelines must be related to behavioral health conditions, one (1) of which may be a behavioral health component of a medical guideline; however, it must address a separate condition or an aspect of a behavioral health condition distinctively different from the behavioral health guideline. One (1) of the behavioral health guidelines should address the treatment of depression. At least two (2) of the CONTRACTOR's adopted clinical practice guidelines shall be the clinical basis for the DM programs described in Section 2.8. The CONTRACTOR shall measure performance against at least two (2) important aspects of each of the four (4) clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two (2) years or whenever the guidelines change.

2.15.5.2 The CONTRACTOR shall distribute the guidelines to all appropriate providers upon signing of the provider agreement and when the guidelines are revised.

2.15.6 **NCQA Accreditation**

2.15.6.1 The CONTRACTOR shall obtain NCQA accreditation by November 30, 2009 and shall maintain it thereafter. Any accreditation status granted by NCQA under the New Health Plan (NHP) program or the MCO Introductory Survey option will not be acknowledged by TENNCARE. Accreditation obtained under the NCQA Full Accreditation Survey or Multiple Product Survey options will be acknowledged by TENNCARE if the TennCare product is specifically included in the NCQA survey. TENNCARE will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by NCQA, in the accreditation of the CONTRACTOR. In order to ensure that the CONTRACTOR is making forward progress, TENNCARE shall require that the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2007	
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	December 15, 2007
CALENDAR YEAR 2008	
Submit copy of signed NCQA Survey contract to TENNCARE	January 15, 2008
Purchase NCQA ISS Tool for 2009 MCO Accreditation Survey	August 15, 2008
Copy of signed contract with NCQA approved vendor to perform 2009 CAHPS surveys (Adult, Child and Children with Chronic Conditions to TENNCARE)	November 15, 2008
Copy of signed contract with NCQA approved vendor to perform 2009 HEDIS Audit to TENNCARE (The CONTRACTOR must perform the complete Medicaid HEDIS Data Set with the exception of dental related measures)	November 15, 2008
CALENDAR YEAR 2009	
Notify TENNCARE of date for ISS Submission and NCQA On-site review	January 15, 2009
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor, TENNCARE, and the EQRO	February 15, 2009
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TENNCARE	June 15, 2009
Finalize preparations for NCQA Survey (Final payment must be submitted to NCQA sixty (60) calendar days prior to submission of ISS)	Notify TennCare of final payment within five (5) business days of submission to NCQA.

EVENT	REQUIRED DEADLINE
Submission of ISS to NCQA	Notify TennCare within five (5) business days of submission to NCQA.
NCQA Survey Completed and copy of NCQA Final Report to TENNCARE: • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within twelve (12) months. • Accreditation Denied – Results in termination of this Agreement.	November 30, 2009

2.15.6.2 If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 4.4 of this Agreement.

2.15.6.3 Failure to obtain NCQA accreditation by November 30, 2009 and maintain accreditation thereafter shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 4.4 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of Final Report from NCQA and may result in termination of this Agreement in accordance with Section 4.4 of this Agreement.

2.15.7 **HEDIS and CAHPS**

2.15.7.1 Annually, beginning with HEDIS 2009, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

2.15.7.2 Annually, beginning in 2009, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2009.

2.16 MARKETING

The CONTRACTOR shall not conduct any marketing activities, as defined in Section 1 of this Agreement. This prohibition includes, but is not limited to the following information and activities:

2.16.1 Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.

2.16.2 Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;

2.16.2.1 Offers of gifts or material or financial gain as incentives to enroll;

2.16.2.2 Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

2.16.2.3 Direct solicitation of prospective enrollees;

2.16.2.4 Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

2.16.2.5 Assertions or statements (whether oral or written) that the enrollee must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits;

2.16.2.6 Assertions or statements (whether written or oral) that the CONTRACTOR is endorsed by CMS, the federal or state government or similar entity;

2.16.2.7 Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions; and

2.16.2.8 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

2.17 MEMBER MATERIALS

2.17.1 Prior Approval Process for All Member Materials

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior approval all materials that will be distributed to members (referred to as member materials). This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, Section 2.17 and Section 2.7.3, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

2.17.1.2 All member materials shall be submitted to TENNCARE on paper and electronic file media, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement must be submitted for approval; however, unless otherwise requested by TENNCARE, an electronic file for these materials is not required. The electronic files must be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.

2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.

2.17.1.4 Once member materials have been approved by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.

2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.

2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

2.17.2 **Written Material Guidelines**

The CONTRACTOR shall comply with the following requirements as it relates to written member materials:

2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;

2.17.2.2 All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved by TENNCARE;

2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 4.32.1;

2.17.2.4 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:

2.17.2.4.1 The Seal of the State of Tennessee;

2.17.2.4.2 The TennCare name unless the initials "SM" denoting a service mark, is superscripted to the right of the name (TennCare[sm]);

2.17.2.4.3 The word "free" unless the service is at no cost to all members. If members have cost sharing responsibilities, the service is not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; and

2.17.2.4.4 The use of phrases to encourage enrollment such as "keep your doctor" implying that enrollees can keep all of their physicians. Enrollees in TennCare should not be led to think that they can continue to go to their current physician, unless that particular physician is a contract provider with the CONTRACTOR's MCO;

2.17.2.5 All vital CONTRACTOR documents must be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR documents must be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;

2.17.2.6 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;

2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member; and

2.17.2.8 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2.17.3 **Distribution of Member Materials**

2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Agreement. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, and identification cards.

2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section 2.17, to members in order to promote health and/or educate enrollees.

2.17.4 **Member Handbooks**

2.17.4.1 The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.

2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section 2.4.5 and at

least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.

2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.

2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.

2.17.4.5 Each member handbook shall, at a minimum, be in accordance with the following guidelines:

2.17.4.5.1 Must be in accordance with all applicable requirements as described in Section 2.17.2 of this Agreement;

2.17.4.5.2 Shall include a table of contents;

2.17.4.5.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;

2.17.4.5.4 Shall include a description of services provided including benefit limits and thresholds, including how reaching service thresholds may trigger enrollment in MCO case management or disease management, exclusions, and use of non-contract providers;

2.17.4.5.5 Shall include descriptions of both the Medicaid Benefits and the Standard Benefits;

2.17.4.5.6 Shall include a description of TennCare cost sharing responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing responsibilities and of their right to appeal in the event that they are billed for amounts other than their TennCare cost sharing responsibilities;

2.17.4.5.7 Shall include information about preventive services for adults and children, including TENNderCare, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;

2.17.4.5.8 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;

2.17.4.5.9 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;

2.17.4.5.10 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse line. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse line when they have questions as to whether they should go to the emergency room;

2.17.4.5.11 Shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;

2.17.4.5.12 Shall include appeal procedures as described in Section 2.19 of this Agreement;

2.17.4.5.13 Shall include notice that in addition to the member's right to file an appeal directly to TENNCARE for actions taken by the CONTRACTOR, the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;

2.17.4.5.14 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;

2.17.4.5.15 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;

2.17.4.5.16 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section 2.9.2 of this Agreement;

2.17.4.5.17 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;

2.17.4.5.18 Shall include notice that a new member may request to change MCOs at anytime during the forty-five (45) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.5.19 Shall include notice that the member may change MCOs at the next choice period as described in Section 2.4.7.2.2 of this Agreement and shall have a forty-five (45) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.5.20 Shall include notice that the member has the right to appeal to TENNCARE to request to change MCOs based on hardship and how to do so;

2.17.4.5.21 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;

2.17.4.5.22 Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program as well as the service/information that may be obtained from each line;

2.17.4.5.23 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.4.5.24 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;

2.17.4.5.25 Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section 2.13.5);

2.17.4.5.26 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

2.17.4.5.27 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

2.17.4.5.28 Shall include information on appropriate prescription drug usage (see Section 2.9.7); and

2.17.4.5.29 Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

2.17.5 **Quarterly Member Newsletter**

2.17.5.1 The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.2.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.5.2.3 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;

2.17.5.2.4 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;

2.17.5.2.5 Information about appropriate prescription drug usage;

2.17.5.2.6 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and

2.17.5.2.7 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."

2.17.5.3 The quarterly member newsletter shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletter and the date that the information was mailed to members along with an invoice or other type of documentation to indicate the date and volume of the quarterly member newsletter mailing.

2.17.6 **Identification Card**

Each member shall be provided an identification card, which identifies the member as a participant in the TennCare program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's MCO or prior to the member's enrollment effective date. The identification card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), must comply with all state and federal requirements and, at a minimum, shall include:

2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;

2.17.6.2 Phone numbers for information and/or authorizations, including for behavioral health services;

2.17.6.3 Descriptions of procedures to be followed for emergency or special services;

2.17.6.4 The member's identification number;

2.17.6.5 The member's name (First, Last and Middle Initial);

2.17.6.6 The member's date of birth;

2.17.6.7 The member's enrollment effective date;

2.17.6.8 Copayment information;

2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier; and

2.17.6.10 The words "Medicaid" or "Standard" based on eligibility.

2.17.7 **Provider Directory**

2.17.7.1 The CONTRACTOR shall distribute provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

2.17.7.2 Provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider

directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual provider directory.

2.17.7.3 Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post-stabilization services, identification of providers accepting new patients and whether or not a provider performs TENNderCare screens.

2.17.8 Additional Information Available Upon Request

The CONTRACTOR shall provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it:

2.17.8.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and

2.17.8.2 Information regarding physician incentive plans, including but not limited to:

2.17.8.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;

2.17.8.2.2 The type of incentive arrangement;

2.17.8.2.3 Whether stop-loss protection is provided; and

2.17.8.2.4 If the CONTRACTOR was required to conduct a survey, a summary of the survey results.

2.18 CUSTOMER SERVICE

2.18.1 Member Services Toll-Free Phone Line

2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, comments, and inquiries from the member, the member's family, or the member's provider.

2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.1.3 The member services information line shall handle calls from non-English speaking callers as well as calls from members who are hearing impaired.

2.18.1.4 The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m. Central Time Monday through Friday, except State of Tennessee holidays.

2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section 2.18.1.

2.18.1.6 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, and the CONTRACTOR's provider network.

2.18.1.7 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.1.8 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.1.9 <u>Performance Standards for Member Services Line/Queue</u>

2.18.1.9.1 The CONTRACTOR shall adequately staff the member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.1.9.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.

2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written polices and procedures for the provision of language interpreter and translation services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.

2.18.2.2 The CONTRACTOR shall provide interpreter and translation services free of charge to members.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

2.18.3 **Cultural Competency**

As required by 42 CFR 438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

2.18.4 **Provider Services and Utilization Management Toll-Free Telephone Line**

2.18.4.1 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.4.3 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m. Central Time, Monday through Friday, except State of Tennessee holidays.

2.18.4.4 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding prior authorization requests as described in Section 2.14.2 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.5 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, prior authorization and referral requirements, and the CONTRACTOR's provider network.

2.18.4.6 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.7 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.4.8 <u>Performance Standards for UM Line/Queue</u>

2.18.4.8.1 The CONTRACTOR shall adequately staff the provider service line to ensure that the utilization management line/queue meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.4.8.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.

2.18.5 **Provider Handbook**

2.18.5.1 The CONTRACTOR shall issue a provider handbook to all contract providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider. At a minimum the provider handbook shall include the following information:

2.18.5.1.1 Description of the TennCare program;

2.18.5.1.2 Covered services;

2.18.5.1.3 Emergency service responsibilities;

2.18.5.1.4 TENNderCare services and standards;

2.18.5.1.5 Information on members' appeal rights;

2.18.5.1.6 Policies and procedures of the provider complaint system;

2.18.5.1.7 Medical necessity standards and clinical practice guidelines;

2.18.5.1.8 PCP responsibilities;

2.18.5.1.9 Coordination with other TennCare contractors or MCO subcontractors;

2.18.5.1.10 Prior authorization, referral and other utilization management requirements and procedures;

2.18.5.1.11 Protocol for encounter data element reporting/records;

2.18.5.1.12 Medical records standard;

2.18.5.1.13 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

2.18.5.1.14 Payment policies; and

2.18.5.1.15 Member rights and responsibilities.

2.18.5.2 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

2.18.6 **Provider Education and Training**

2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Agreement.

2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations.

2.18.6.3 The CONTRACTOR shall also conduct ongoing provider education and training as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement.

2.18.6.4 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.

2.18.7 **Provider Relations**

2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to timely and adequately respond to inquiries, questions and concerns from contract providers. The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Agreement.

2.18.7.2 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, provider complaints and appeals, claims processing, utilization management processes, including medical reviews, and audit and reimbursement. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

2.18.8 **Provider Complaint System**

2.18.8.1 The CONTRACTOR shall establish and maintain a provider complaint system for any provider (contract or non-contract) who is not satisfied with the CONTRACTOR's policies and procedures or a decision made by the contractor that does not impact the provision of services to members.

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-226(b).

2.18.9 **Member Involvement with Behavioral Health Services**

2.18.9.1 The CONTRACTOR shall develop policies and procedures with respect to member, parent, or legally appointed representative involvement with behavioral health. These policies and procedures must include, at a minimum, the following elements:

2.18.9.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

2.18.9.1.2 The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

2.18.9.1.3 The requirement that provider education include materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirement will be met; and

2.18.9.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative involvement in behavioral health treatment planning.

2.18.9.2 The CONTRACTOR shall provide an education plan for all members with behavioral health issues; education must occur on a regular basis. At a minimum, educational materials must include information on medications and their side effects; behavioral health disorders and treatment options; self-help groups, peer support, and other community support services available for members and families.

2.18.9.3 The CONTRACTOR shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s) or legally appointed representative, and adults for whom voluntary inpatient treatment is being considered, of all their options for residential and/or inpatient placement, and alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

2.18.9.4 The CONTRACTOR shall require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

2.19 COMPLAINTS AND APPEALS

2.19.1 General

2.19.1.1 Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2.17.4. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

2.19.1.2 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2.15.2, to the review of member complaints and appeals that have been received.

2.19.1.3 The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2.19.2 **Appeals**

2.19.2.1 The CONTRACTOR's appeal process shall, at a minimum, meet the requirements outlined herein.

2.19.2.2 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should a member choose to appeal in writing, the member will be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2.19.2.3 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

2.19.2.4 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

2.19.2.5 The CONTRACTOR shall identify the appropriate individual or body within the CONTRACTOR's MCO having decision-making authority as part of the appeal procedure.

2.19.2.6 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

2.19.2.7 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2.19.2.8 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2.19.2.9 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the member and TENNCARE.

2.19.2.10 The CONTRACTOR shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.

2.19.2.11 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.

2.19.2.12 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.19.2.13 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

2.19.2.14 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.

2.19.2.15 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.

2.19.2.16 The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2.24.4.

2.19.2.17 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.19.2.18 Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and copayment responsibilities shall be directed to the Department of Human Services.

2.20 FRAUD AND ABUSE

2.20.1 General

2.20.1.1 The Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.

2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.

2.20.1.3 The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

2.20.2 Reporting and Investigating Suspected Fraud and Abuse

2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement. The CONTRACTOR shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:

2.20.2.1.1 Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG;

2.20.2.1.2 All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU; and

2.20.2.1.3 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG;

2.20.2.2 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment 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.

2.20.2.3 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to OIG or MFCU, as appropriate.

2.20.2.4 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:

2.20.2.4.1 Contact the subject of the investigation about any matters related to the investigation;

2.20.2.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

2.20.2.4.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

2.20.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

2.20.2.6 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

2.20.2.7 The State shall not transfer its law enforcement functions to the CONTRACTOR.

2.20.2.8 The CONTRACTOR and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.

2.20.2.9 The CONTRACTOR shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.

2.20.2.10 Except as described in Section 2.11.7.2 of this Agreement, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.

2.20.3 **Compliance Plan**

2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Agreement execution.

2.20.3.2 The CONTRACTOR’s fraud and abuse compliance plan shall:

2.20.3.2.1 Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Agreement;

2.20.3.2.2 Ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;

2.20.3.2.3 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Agreement; and

2.20.3.2.4 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:

2.20.3.2.4.1 Claims edits;

2.20.3.2.4.2 Post-processing review of claims;

2.20.3.2.4.3 Provider profiling and credentialing;

2.20.3.2.4.4 Prior authorization;

2.20.3.2.4.5 Utilization management;

2.20.3.2.4.6 Relevant subcontractor and provider agreement provisions; and

2.20.3.2.4.7 Written provider and member material regarding fraud and abuse referrals.

2.20.3.2.5 Contain provisions for the confidential reporting of plan violations to the designated person;

2.20.3.2.6 Contain provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;

2.20.3.2.7 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;

2.20.3.2.8 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

2.20.3.2.9 Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG; and

2.20.3.2.10 Ensure that no individual who reports MCO violations or suspected fraud and abuse is retaliated against.

2.20.3.3 The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.

2.20.3.4 The CONTRACTOR shall report fraud and abuse activities as required in Section 2.30.13, Reporting Requirements.

2.21 FINANCIAL MANAGEMENT

The CONTRACTOR shall be responsible for sound financial management of its MCO. The CONTRACTOR shall adhere to the minimum guidelines outlined below.

2.21.1 Capitation Payments

The CONTRACTOR shall accept capitation payments, remitted by TENNCARE in accordance with Section 3 and incentive payments, if applicable, as payment in full for all services required pursuant to this Agreement.

2.21.2 Savings/Loss

2.21.2.1 The CONTRACTOR shall not be required to share with TENNCARE any financial gains realized under this Agreement.

2.21.2.2 TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

2.21.3 Interest

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion.

2.21.4 Third Party Liability Resources

2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party.

2.21.4.1.1 If the CONTRACTOR has determined that third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

2.21.4.1.2 If the CONTRACTOR has determined that TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.

2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for one of these services:

2.21.4.1.3.1 TENNderCare;

2.21.4.1.3.2 Prenatal or preventive pediatric care; or

2.21.4.1.3.3 All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.

2.21.4.1.4 The claims specified in Sections 2.21.4.1.3.1, 2.21.4.1.3.2, and 2.21.4.1.3.3 will be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.

2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2.21.4 of this Agreement

2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee.

2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for the purposes of reporting.

2.21.4.6 TennCare cost sharing responsibilities permitted pursuant to Section 2.6.7 of this Agreement shall not be considered TPL.

2.21.4.7 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.

2.21.4.8 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.

2.21.4.9 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.

2.21.4.10 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.

2.21.4.11 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries.

TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.21.5 **Solvency Requirements**

2.21.5.1 Minimum Net Worth

2.21.5.1.1 Until the CONTRACTOR has provided services under this Agreement for a full calendar year, the CONTRACTOR shall establish and maintain a minimum net worth equal to the greater of:

2.21.5.1.1.1 One million five-hundred thousand dollars ($1,500,000); or

2.21.5.1.1.2 An amount totaling four percent (4%) of the first one-hundred fifty million dollars ($150,000,000) of the CONTRACTOR's TennCare revenue which shall be calculated by: totaling the weighted average capitation rate, as determined by TENNCARE by multiplying the base capitation rates originally proposed by the CONTRACTOR and the priority add-on and State Only and Judicial capitation rates effective on the start date of operations specified by the State by the number of enrollees (for the appropriate rate cell) assigned to the CONTRACTOR thirty (30) calendar days prior to the start date of operations for enrollment effective on the start date of operations.

2.21.5.1.2 In the event that actual enrollment as of sixty (60) days after the start date of operations increased or decreased by more than ten percent (10%) over enrollment as of thirty (30) calendar days prior to the start date of operations, the minimum net worth requirement specified in Section 2.21.5.1.1 shall be recalculated to reflect actual enrollment as of sixty (60) calendar days after the start date of operations.

2.21.5.1.3 After the CONTRACTOR has provided services under this Agreement for a full calendar year, the CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-212.

2.21.5.1.4 Any and all payments made by TENNCARE, including capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-212.

2.21.5.1.5 The CONTRACTOR shall demonstrate evidence of its compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR. The CONTRACTOR agrees that failure to maintain any of the financial requirements in accordance with this Section 2.21.5.1 through 2.21.5.5, as determined by TDCI, shall constitute hazardous financial conditions as defined by TCA 56-32-212.

2.21.5.2 Statutory Net Worth for Enhanced Enrollment

In the event of a significant enrollment expansion as defined in TCA 56-32-203(c)(2):

2.21.5.2.1 The CONTRACTOR agrees that in order to maintain the minimum net worth requirements described in Section 2.21.5.1, the minimum net worth requirements are to be recalculated.

2.21.5.2.2 The calculation of minimum net worth shall be based upon annual projected premiums including the estimated premiums for the additional enrollment versus the prior year actual premium revenue. Estimated premiums will be based on the capitation payment rates in effect at the time of the calculation and projected future enrollment. The formula set forth in TCA 56-32-212(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement.

2.21.5.2.3 The CONTRACTOR must demonstrate to the satisfaction of TDCI that this enhanced minimum net worth balance has been established prior to the assignment of additional enrollees to the CONTRACTOR by TENNCARE.

2.21.5.2.4 The CONTRACTOR shall maintain the greater of the enhanced minimum net worth balance or the minimum net worth balance calculated pursuant to TCA 56-32-212, until the CONTRACTOR has completed a full calendar year with the significantly expanded enrollment.

2.21.5.3 Restricted Deposits

The CONTRACTOR shall achieve and maintain restricted deposits in an amount equal to the net worth requirement specified in Section 2.21.5.1. TDCI shall calculate the amount of restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-212 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement.

2.21.5.4 Restricted Deposits for Enhanced Enrollment

In the event of an increase in the CONTRACTOR's statutory net worth requirement as a result of a significant enrollment expansion as defined in TCA 56-32-203(c)(2), the CONTRACTOR shall increase its restricted deposit to equal its enhanced minimum net worth requirement required by Section 2.21.5.2. TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-212 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement. The CONTRACTOR must demonstrate to the satisfaction of TDCI that the CONTRACTOR has increased its restricted deposit in accordance with this Section prior to the assignment of additional enrollees to the CONTRACTOR by TENNCARE.

2.21.5.5 Liquidity Ratio Requirement

In addition to the positive working capital requirement described in TCA 56-32-212, the CONTRACTOR shall maintain a liquidity ratio where admitted assets consisting of cash, cash equivalents, short-term investments and bonds exceed total liabilities as reported on the NAIC financial statements.

2.21.5.6 If the CONTRACTOR fails to meet the applicable net worth and/or restricted deposit requirement, said failure shall constitute a hazardous financial condition and the CONTRACTOR shall be considered to be in breach of the terms of the Agreement.

2.21.6 **Accounting Requirements**

2.21.6.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.

2.21.6.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in this Agreement.

2.21.7 **Insurance**

2.21.7.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Agreement. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.

2.21.7.2 The CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.

2.21.7.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.

2.21.7.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.

2.21.7.5 Failure to provide proof of adequate coverage within the specified time period may result in this Agreement being terminated.

2.21.8 **Ownership and Financial Disclosure**

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made in accordance with the requirements in Section 2.30.14.2. The following information shall be disclosed:

2.21.8.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

2.21.8.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;

2.21.8.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;

2.21.8.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;

2.21.8.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:

2.21.8.5.1 The CONTRACTOR shall disclose the following transactions:

2.21.8.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;

2.21.8.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and

2.21.8.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

2.21.8.5.2 The information which must be disclosed in the transactions includes:

2.21.8.5.2.1 The name of the party in interest for each transaction;

2.21.8.5.2.2 A description of each transaction and the quantity or units involved;

2.21.8.5.2.3 The accrued dollar value of each transaction during the fiscal year; and

2.21.8.5.2.4 Justification of the reasonableness of each transaction.

2.21.8.5.3 If the Agreement is being renewed or extended, the CONTRACTOR must 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 must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions must be reported.

2.21.8.5.4 A party in interest is:

2.21.8.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

2.21.8.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

2.21.8.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or

2.21.8.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.8.5.4.1, 2.21.8.5.4.2, or 2.21.8.5.4.3

2.21.8.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

2.21.9 **Internal Audit Function**

The CONTRACTOR shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The CONTRACTOR's internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the

operations of the department. Further, the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section 2.22.6 of this Agreement.

2.21.10 **Audit of Business Transactions**

2.21.10.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the requirements in Section 2.30.14.3.5 of this Agreement.

2.21.10.2 The agreement for such audits shall be subject to prior approval of the Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". In the event that terms included in the standard contract to audit accounts differ from those contained in this Agreement, this Agreement takes precedent.

2.22 CLAIMS MANAGEMENT

2.22.1 **General**

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, and compliance with all applicable state and federal laws, rules and regulations.

2.22.2 **Claims Management System Capabilities**

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service, date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track service use against hard benefit limits and service thresholds in accordance with a methodology set by TENNCARE.

2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.).

2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section 2.23 of this Agreement.

2.22.2.4 As part of this ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.

2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.22.2.6 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

2.22.3 **Paper Based Claims Formats**

2.22.3.1 The CONTRACTOR shall comply at all times with standardized paper billing forms/formats (and all future updates) as follows:

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450
Dental	ADA

2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.

2.22.3.3 For the forms identified in Section 2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.

2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

2.22.4 **Prompt Payment**

2.22.4.1 The CONTRACTOR shall comply with prompt pay claims processing requirements in accordance with TCA 56-32-226.

2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.

2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for covered services delivered to a TennCare enrollee. The terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-226(b)(1)(A) and (B).

2.22.4.4 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

2.22.4.5 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.

2.22.4.6 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR's MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment.

2.22.4.7 As it relates to MCO Assignment Unknown (see Sections 2.13.7 and 2.13.8), the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.22.5 Claims Dispute Management

2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved by TENNCARE prior to its implementation.

2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-226.

2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

2.22.6 Claims Payment Accuracy – Minimum Audit Procedures

2.22.6.1 On a quarterly basis the CONTRACTOR shall submit a claims payment accuracy percentage report (see Section 2.30.15).

2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section 2.21.9 of this Agreement.

2.22.6.3 The audit shall utilize a random sample of all "processed or paid" claims upon initial submission in each quarter (the terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-226(b)(1)(A) and (B)). A minimum sample of three-hundred (300) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the quarter tested is required. The sample shall be further decomposed into minimum sub-samples of one-hundred (100) claims randomly selected from the entire population of claims processed and paid upon initial submission for each month in the quarter.

2.22.6.4 The minimum attributes to be tested for each claim selected shall include:

2.22.6.4.1 Claim data correctly entered into the claims processing system;

2.22.6.4.2 Claim is associated to the correct provider;

2.22.6.4.3 Service obtained the proper authorization;

2.22.6.4.4 Member eligibility at processing date correctly applied;

2.22.6.4.5 Allowed payment amount agrees with contracted rate;

2.22.6.4.6 Duplicate payment of the same claim has not occurred;

2.22.6.4.7 Denial reason applied appropriately;

2.22.6.4.8 Copayment application considered and applied;

2.22.6.4.9 Effect of modifier codes correctly applied;

2.22.6.4.10 Processing considered if service subject to hard benefit limits considered and applied;

2.22.6.4.11 Other insurance properly considered and applied;

2.22.6.4.12 Application of hard benefit limits; and

2.22.6.4.13 Proper coding including bundling/unbundling.

2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:

2.22.6.5.1 Results for each attribute tested for each claim selected;

2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;

2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;

2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and

2.22.6.5.5 Claims processed or paid in error have been corrected.

2.22.7 **Claims Processing Methodology Requirements**

2.22.7.1 The CONTRACTOR shall perform front end system edits, including but not limited to:

2.22.7.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

2.22.7.1.2 Third party liability (TPL);

2.22.7.1.3 Medical necessity (e.g., appropriate age/sex for procedure);

2.22.7.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;

2.22.7.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;

2.22.7.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;

2.22.7.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted;

2.22.7.1.8 Quantity of service: the system shall evaluate claims for services provided to members to ensure that any applicable hard benefit limits are applied; and

2.22.7.1.9 Benefit limits: the system shall ensure that hard benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid.

2.22.7.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., not in the future or outside of a member's TennCare eligibility span.

2.22.7.3 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary.

2.22.7.4 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

2.22.8 **Explanation of Benefits (EOBs) and Related Functions**

2.22.8.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.

2.22.8.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.

2.22.8.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall include: claims for services with hard benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

2.22.8.4 Regarding the paid claims sample referenced in Section 2.22.6.3, the CONTRACTOR shall stratify said sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CONTRACTOR considers a particular specialty (or provider) to warrant closer scrutiny, the CONTRACTOR may over sample the group. The paid claims sample should be a minimum of twenty-five (25) claims per check run with a minimum of 100 claims per month.

2.22.8.5 Based on the EOBs sent to TennCare enrollees, the CONTRACTOR shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The CONTRACTOR shall use the feedback received to modify or enhance the EOB sampling methodology.

2.22.9 **Remittance Advices and Related Functions**

2.22.9.1 In concert with its claims payment cycle the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the CONTRACTOR.

2.22.9.2 The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.

2.22.9.3 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice must specifically identify all such information and documentation.

2.22.9.4 In accordance with 42 CFR 455.18 and 455.19, the following statement must be included on each remittance advice sent to providers: ''I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

2.22.10 **Processing of Payment Errors**

The CONTRACTOR shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from TENNCARE.

2.22.11 **Notification to Providers**

For purposes of network management, the CONTRACTOR shall, at a minimum, notify all contract providers to file claims associated with covered services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

2.22.12 **Payment Cycle**

At a minimum, the CONTRACTOR shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CONTRACTOR and approved by TENNCARE.

2.22.13 **Excluded Providers**

2.22.13.1 The CONTRACTOR shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with TENNCARE.

2.22.13.2 The CONTRACTOR shall not pay any claim submitted by a provider that is on payment hold under the authority of TENNCARE.

2.23 INFORMATION SYSTEMS

2.23.1 **General Provisions**

2.23.1.1 Systems Functions

The CONTRACTOR shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet TENNCARE and federal reporting requirements and other Agreement requirements and that are in compliance with this Agreement and all applicable state and federal laws, rules and regulations including HIPAA.

2.23.1.2 Systems Capacity

The CONTRACTOR's Systems shall possess capacity sufficient to handle the workload projected for the start date of operations and will be scaleable and flexible so they can be adapted as needed, within negotiated time frames, in response to changes in Agreement requirements, increases in enrollment estimates, etc.

2.23.1.3 Electronic Messaging

2.23.1.3.1 The CONTRACTOR shall provide a continuously available electronic mail communication link (e-mail system) with TENNCARE.

2.23.1.3.2 The e-mail system shall be capable of attaching and sending documents created using software products other than CONTRACTOR's Systems, including TENNCARE's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

2.23.1.3.3 As needed, the CONTRACTOR shall be able to communicate with TENNCARE using TENNCARE's e-mail system over a secure virtual private network (VPN).

2.23.1.3.4 As needed, based on the sensitivity of data contained in an electronic message, the CONTRACTOR shall support network-to-network encryption of said messages.

2.23.1.4 Participation in Information Systems Work Groups/Committees

The CONTRACTOR and TENNCARE shall establish an information systems work group/committee to coordinate activities and develop cohesive systems strategies among TENNCARE and the MCOs. The Work Group will meet on a designated schedule as agreed to by TENNCARE and the CONTRACTOR.

2.23.1.5 Connectivity to TENNCARE/State Network and Systems

The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

2.23.1.6 Systems Refresh Plan

The CONTRACTOR shall provide to TENNCARE an annual Systems refresh plan (see Section 2.30.16). The plan shall outline how Systems within the CONTRACTOR's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan will also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

2.23.2 **Data and Document Management Requirements**

2.23.2.1 Adherence to Data and Document Management Standards

2.23.2.1.1 The CONTRACTOR's Systems shall conform to the data and document management standards by information type/subtype detailed in the HIPAA Implementation and TennCare Companion guides, inclusive of the standard transaction code sets specified in the guides.

2.23.2.1.2 The CONTRACTOR's Systems shall conform to HIPAA standards for data and document management that are currently under development within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE.

2.23.2.2 Data Model and Accessibility

The CONTRACTOR's Systems shall be SQL and/or ODBC compliant; alternatively, the CONTRACTOR's Systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain said databases.

2.23.2.3 Data and Document Relationships

2.23.2.3.1 When the CONTRACTOR houses indexed images of documents used by members and providers to transact with the CONTRACTOR the CONTRACTOR shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider identification number.

2.23.2.3.2 The CONTRACTOR shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about a reported problem.

2.23.2.3.3 Upon TENNCARE request, the CONTRACTOR shall be able to generate a listing of all members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The CONTRACTOR shall also be able to generate a sample of said document.

2.23.2.4 Information Retention

2.23.2.4.1 The CONTRACTOR shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements. The plan shall comply with the applicable requirements of the Tennessee Department of General Services, Records Management Division.

2.23.2.4.2 The CONTRACTOR shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.

2.23.2.4.3 The CONTRACTOR shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.

2.23.2.4.4 If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.23.2.5 Information Ownership

All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Agreement is owned by TENNCARE. The CONTRACTOR is expressly prohibited from sharing or publishing TENNCARE information and reports without the prior written consent of TENNCARE.

2.23.3 **System and Data Integration Requirements**

2.23.3.1 Adherence to Standards for Data Exchange

2.23.3.1.1 The CONTRACTOR's Systems shall be able to transmit, receive and process data in HIPAA-compliant or TENNCARE-specific formats and methods, including but not limited to secure File Transfer Protocol (FTP) over a secure connection such as a VPN, that are in use at the start of Systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

2.23.3.1.2 The CONTRACTOR's Systems shall conform to future federal and/or TENNCARE specific standards for data exchange within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE. The CONTRACTOR shall partner with TENNCARE in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

2.23.3.2 HIPAA Compliance Checker

All HIPAA-conforming exchanges of data between TENNCARE and the CONTRACTOR shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

2.23.3.3 TENNCARE/State Website/Portal Integration

Where deemed that the CONTRACTOR's Web presence will be incorporated to any degree to TENNCARE's or the state's web presence/portal, the CONTRACTOR shall conform to the applicable TENNCARE or state standards for website structure, coding and presentation.

2.23.3.4 Connectivity to and Compatibility/Interoperability with TENNCARE Systems and IS Infrastructure

2.23.3.4.1 The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

2.23.3.4.2 All of the CONTRACTOR's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with TENNCARE and/or state systems and shall conform to applicable standards and specifications set by TENNCARE and/or the state agency that owns the system.

2.23.3.5 Data Exchange in Support of TENNCARE's Program Integrity and Compliance Functions

The CONTRACTOR's System(s) shall be capable of generating files in the prescribed formats for upload into TENNCARE Systems used specifically for program integrity and compliance purposes.

2.23.3.6 Address Standardization

The CONTRACTOR's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

2.23.4 **Encounter Data Provision Requirements (Encounter Submission and Processing)**

2.23.4.1 Adherence to HIPAA Standards

The CONTRACTOR's Systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

2.23.4.2 Quality of Submission

2.23.4.2.1 The CONTRACTOR shall submit encounter data that meets established TENNCARE data quality standards. These standards are defined by TENNCARE to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TENNCARE will revise and amend these standards as necessary to ensure continuous quality improvement. The CONTRACTOR shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with TENNCARE data quality standards as originally defined or subsequently amended. The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the CONTRACTOR denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the CONTRACTOR shall submit all available claim data to TENNCARE without alteration or omission. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR must require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims (see Section 2.12.7.31); the CONTRACTOR shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TENNCARE, in order to support comprehensive financial reporting and utilization analysis. The CONTRACTOR must submit

encounter data according to standards and formats as defined by TENNCARE, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Due to the need for timely data and to maintain integrity of processing sequence, the CONTRACTOR shall address any issues that prevent processing of an encounter batch in accordance with procedures specified in Section 2.23.13.

2.23.4.2.2 TENNCARE will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by TENNCARE to ensure accurate processing or encounter data quality, and will return these transactions to the CONTRACTOR for research and resolution. TENNCARE will require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats, in accordance with the procedure specified in Section 2.23.13. Generally the CONTRACTOR shall, unless otherwise directed by TENNCARE, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. TENNCARE may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section 2.23.13.

2.23.4.3 <u>Provision of Encounter Data</u>

2.23.4.3.1 Within forty-eight (48) hours of the end of a payment cycle the CONTRACTOR shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources.

2.23.4.3.2 Any encounter data from a subcontractor shall be included in the file from the CONTRACTOR. The CONTRACTOR shall not submit separate encounter files from subcontractors.

2.23.4.3.3 The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CONTRACTOR has a capitation arrangement.

2.23.4.3.4 The level of detail associated with encounters from providers with whom the CONTRACTOR has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CONTRACTOR received and settled a fee-for-service claim.

2.23.4.3.5 The CONTRACTOR shall adhere to federal and/or TENNCARE payment rules in the definition and treatment of certain data elements, e.g., units of service, that are standard fields in the encounter data submissions and will be treated similarly by TENNCARE across all MCOs.

2.23.4.3.6 The CONTRACTOR shall provide encounter data files electronically to TENNCARE in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.

2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio reports and supply the reconciliation to TENNCARE with each of the Medical Loss Ratio report submissions as specified in Section 2.30.14.2.1.

2.23.4.3.8 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CONTRACTOR's applicable reimbursement methodology for that service.

2.23.4.3.9 The CONTRACTOR shall be able to receive, maintain and utilize data extracts from TENNCARE and its contractors, e.g., pharmacy data from TENNCARE or its PBM.

2.23.5 **Eligibility and Enrollment Data Exchange Requirements**

2.23.5.1 The CONTRACTOR shall receive, process and update enrollment files sent daily by TENNCARE.

2.23.5.2 The CONTRACTOR shall update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.

2.23.5.3 The CONTRACTOR shall transmit to TENNCARE, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides or as otherwise specified by TENNCARE: member address changes, telephone number changes, and PCP.

2.23.5.4 The CONTRACTOR shall be capable of uniquely identifying a distinct TennCare member across multiple populations and Systems within its span of control.

2.23.5.5 The CONTRACTOR shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TENNCARE, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

2.23.6 **System and Information Security and Access Management Requirements**

2.23.6.1 The CONTRACTOR's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

2.23.6.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

2.23.6.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by TENNCARE and the CONTRACTOR; and

2.23.6.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

2.23.6.2 The CONTRACTOR shall make System information available to duly authorized representatives of TENNCARE and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

2.23.6.3 The CONTRACTOR's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CONTRACTOR and TENNCARE.

2.23.6.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

2.23.6.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

2.23.6.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

2.23.6.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

2.23.6.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

2.23.6.4.5 Facilitate auditing of individual records as well as batch audits; and

2.23.6.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within 48 hours.

2.23.6.5 The CONTRACTOR's Systems shall have inherent functionality that prevents the alteration of finalized records.

2.23.6.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CONTRACTOR shall provide TENNCARE with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.

2.23.6.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

2.23.6.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

2.23.6.9 The CONTRACTOR shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR's span of control. This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

2.23.6.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by TENNCARE.

2.23.6.11 The CONTRACTOR shall comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate federal agencies.

2.23.7 **Systems Availability, Performance and Problem Management Requirements**

2.23.7.1 The CONTRACTOR shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to Confirmation of MCO Enrollment (CME), ECM, and self-service customer service functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by TENNCARE and the CONTRACTOR. Unavailability caused by events outside of a CONTRACTOR's span of control is outside of the scope of this requirement.

2.23.7.2 The CONTRACTOR shall ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m. Central Time Monday through Friday.

2.23.7.3 The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with TENNCARE are available and operational according to specifications and the data exchange schedule.

2.23.7.4 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.

2.23.7.5 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and the availability of critical information as defined in this Section of the Agreement, including any problems impacting scheduled exchanges of data between the CONTRACTOR and TENNCARE, the CONTRACTOR shall notify the applicable TennCare staff via phone, fax and/or electronic mail within sixty (60) minutes of such discovery. In its notification the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes.

2.23.7.6 Where the problem results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, the CONTRACTOR shall notify the applicable TENNCARE staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.

2.23.7.7 The CONTRACTOR shall provide to appropriate TENNCARE staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

2.23.7.8 The CONTRACTOR shall resolve unscheduled System unavailability of CME and ECM functions, caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control, and shall implement the restoration of services, within sixty (60) minutes of the official declaration of System unavailability. Unscheduled System unavailability to all other CONTRACTOR System functions caused by systems and telecommunications technologies within the CONTRACTOR's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.

2.23.7.9 Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CONTRACTOR's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period.

2.23.7.10 The CONTRACTOR shall not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CONTRACTOR's span of control.

2.23.7.11 Within five (5) business days of the occurrence of a problem with system availability, the CONTRACTOR shall provide TENNCARE with full written documentation that includes a corrective action plan describing how the CONTRACTOR will prevent the problem from occurring again.

2.23.7.12 Business Continuity and Disaster Recovery (BC-DR) Plan

2.23.7.12.1 Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved by TENNCARE.

2.23.7.12.2 At a minimum the CONTRACTOR's BC-DR plan shall address the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

2.23.7.12.3 The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

2.23.7.12.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions per the standards outlined elsewhere in this Section, Section 2.23 of the Agreement.

2.23.7.12.5 The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 2.30.16.

2.23.8 **System User and Technical Support Requirements**

2.23.8.1 The CONTRACTOR shall provide Systems Help Desk (SHD) services to all TENNCARE staff and the other agencies that may have direct access to CONTRACTOR systems.

2.23.8.2 The CONTRACTOR's SHD shall be available via local and toll-free telephone service and via e-mail from 7 a.m. to 7 p.m. Central Time Monday through Friday, with the exception of State of Tennessee holidays. Upon TENNCARE request, the CONTRACTOR shall staff the SHD on a state holiday, Saturday, or Sunday.

2.23.8.3 The CONTRACTOR's SHD staff shall answer user questions regarding CONTRACTOR System functions and capabilities; report recurring programmatic and operational problems to appropriate CONTRACTOR or TENNCARE staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate TENNCARE login account administrator.

2.23.8.4 The CONTRACTOR shall ensure individuals who place calls to the SHD between the hours of 7 p.m. and 7 a.m. Central Time shall be able to leave a message. The CONTRACTOR's SHD shall respond to messages by noon the following business day.

2.23.8.5 The CONTRACTOR shall ensure recurring problems not specific to System unavailability identified by the SHD shall be documented and reported to CONTRACTOR management within one (1) business day of recognition so that deficiencies are promptly corrected.

2.23.8.6 The CONTRACTOR shall have an IS service management system that provides an automated method to record, track and report on all questions and/or problems reported to the SHD.

2.23.9 **System Testing and Change Management Requirements**

2.23.9.1 The CONTRACTOR shall notify the applicable TENNCARE staff person of the following changes to Systems within its span of control within at least ninety (90) calendar days of the projected date of the change.

2.23.9.1.1 Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, and encounter data management; and

2.23.9.1.2 Conversions of core transaction management Systems.

2.23.9.2 If so directed by TENNCARE, the CONTRACTOR shall discuss the proposed change in the Systems work group.

2.23.9.3 The CONTRACTOR shall respond to TENNCARE notification of System problems not resulting in System unavailability according to the following time frames:

2.23.9.3.1 Within five (5) calendar days of receiving notification from TENNCARE the CONTRACTOR shall respond in writing to notices of system problems.

2.23.9.3.2 Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

2.23.9.3.3 The CONTRACTOR shall correct the deficiency by an effective date to be determined by TENNCARE.

2.23.9.3.4 The CONTRACTOR's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

2.23.9.3.5 The CONTRACTOR shall put in place procedures and measures for safeguarding against unauthorized modifications to CONTRACTOR Systems.

2.23.9.4 Valid Window for Certain System Changes

Unless otherwise agreed to in advance by TENNCARE as part of the activities described in this Section 2.23.9, the CONTRACTOR shall not schedule System unavailability to perform System maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

2.23.9.5 Testing

2.23.9.5.1 The CONTRACTOR shall work with TENNCARE pertaining to any testing initiative as required by TENNCARE.

2.23.9.5.2 The CONTRACTOR shall provide sufficient system access to allow testing by TENNCARE of the CONTRACTOR's systems during readiness review (see Section 2.1.2) and as required during the term of the Agreement.

2.23.10 **Information Systems Documentation Requirements**

2.23.10.1 The CONTRACTOR shall ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

2.23.10.2 The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute to TENNCARE distinct System design and management manuals, user manuals and quick/reference guides, and any updates.

2.23.10.3 The CONTRACTOR's System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

2.23.10.4 When a System change is subject to TENNCARE prior approval, the CONTRACTOR shall submit revisions to the appropriate manuals for prior approval before implementing said System changes.

2.23.10.5 All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals will be published in accordance to the appropriate TENNCARE and/or TENNCARE standard.

2.23.10.6 The CONTRACTOR shall update the electronic version of these manuals immediately; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

2.23.11 **Reporting Requirements (Specific to Information Management and Systems Functions and Capabilities)**

2.23.11.1 The CONTRACTOR shall comply with all reporting requirements as described in Section 2.30.16 of this Agreement.

2.23.11.2 The CONTRACTOR shall provide systems-based capabilities for access by authorized TENNCARE personnel, on a secure and read-only basis, to data that can be used in ad hoc reports.

2.23.12 **Other Requirements**

2.23.12.1 Statewide Data Warehouse Requirements

The CONTRACTOR shall participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but will not be limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each MCO.

2.23.12.2 Community Health Record for TennCare Enrollees (Electronic Medical Record)

2.23.12.2.1 At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable time frame, a secure, Web-accessible community health record for TennCare enrollees.

2.23.12.2.2 The design of the Web site for accessing the community health record and the record format and design shall comply with HIPAA, other federal and all state privacy and confidentiality regulations.

2.23.12.2.3 The CONTRACTOR shall provide a Web-based access vehicle for contract providers to the System described in Section 2.23.12.2.1, and shall work with said providers to encourage adoption of this System.

2.23.13 **Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems**

2.23.13.1 Within five (5) business days of receipt of notice from TENNCARE of the occurrence of a problem with the provision and/or intake of an encounter or enrollment file, the CONTRACTOR shall provide TENNCARE with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the CONTRACTOR has addressed or will address the immediate problem and how the CONTRACTOR shall prevent the problem from recurring. In the event that the CONTRACTOR fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TENNCARE, fails to submit a corrective action plan as requested or required, or fails to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, including possible forfeiture of the withhold (see Section 3.9), or be considered a breach of the Agreement.

2.23.13.2 Individual records submitted by the CONTRACTOR may be rejected; these records, once errors therein have been corrected, shall be resubmitted by the CONTRACTOR as stipulated by TENNCARE. In the event that the CONTRACTOR is unable to research or address reported errors in a timely manner as required by TENNCARE, the CONTRACTOR shall submit to TENNCARE a corrective action plan describing how the CONTRACTOR will research and address the errors and how the CONTRACTOR shall prevent the problem from recurring within five (5) business days of receipt of notice from TENNCARE that individual records submitted by the CONTRACTOR have been rejected. In the event that the CONTRACTOR fails to

address or resolve problems with individual records in a timely manner as required by TENNCARE, which shall include failure to submit a corrective action plan as requested or required, or failure to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Continued or repeated failure to address reported errors may result in additional damages or sanctions including possible forfeiture of the withhold (see Section 3.9) or be considered a breach of the Agreement.

2.23.13.3 In the event that the CONTRACTOR fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Agreement, the CONTRACTOR shall submit to TENNCARE a corrective action plan that describes how the failure will be resolved. The corrective action plan shall be delivered within five (5) business days of the conclusion of the test.

2.24 ADMINISTRATIVE REQUIREMENTS

2.24.1 General Responsibilities

2.24.1.1 TENNCARE shall be responsible for management of this Agreement. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 USC 1396a(a)(19).

2.24.1.2 The CONTRACTOR shall be responsible for complying with the requirements of this Agreement and shall act in good faith in the performance of the requirements of this Agreement.

2.24.1.3 The CONTRACTOR shall develop policies and procedures that describe how the CONTRACTOR will comply with the requirements of this Agreement, and the CONTRACTOR shall administer this Agreement in accordance with those policies and procedures unless otherwise directed or approved by TENNCARE.

2.24.1.4 The CONTRACTOR shall submit policies and procedures and other deliverables specified by TENNCARE to TENNCARE for review and/or approval in the format and within the time frames specified by TENNCARE. The CONTRACTOR shall make any changes requested by TENNCARE to policies and procedures or other deliverables and in the time frames specified by TENNCARE.

2.24.1.5 As provided in Section 4.10 of this Agreement, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

2.24.2 Behavioral Health Advisory Committee

The CONTRACTOR shall establish a behavioral health advisory committee that is accountable to the CONTRACTOR's governing body to provide input and advice regarding all aspects of the provision of behavioral health services according to the following requirements:

2.24.2.1 The CONTRACTOR's behavioral health advisory committee must be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority must include families of adults with serious and/or persistent mental illness (SPMI) and families of children with serious emotional disturbance (SED);

2.24.2.2 There must be geographic diversity;

2.24.2.3 There must be cultural and racial diversity;

2.24.2.4 There must be representation by providers and consumers (or family members of consumers) of substance abuse services;

2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee must have input into policy development, planning for services, service evaluation, and member, family member and provider education;

2.24.2.6 Meetings must be held at least quarterly;

2.24.2.7 Travel costs must be paid by the CONTRACTOR;

2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.17; and

2.24.2.9 The CONTRACTOR, as membership changes, must submit current membership lists to the State.

2.24.3 **Performance Standards**

The CONTRACTOR agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment VII.

2.24.4 **Medical Records Requirements**

2.24.4.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.

2.24.4.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:

2.24.4.2.1 Confidentiality of medical records;

2.24.4.2.2 Medical record documentation standards; and

2.24.4.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:

2.24.4.2.3.1 Medical records shall be maintained or available at the site where covered services are rendered;

2.24.4.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section 2.24.4.2.3.3. below) be given copies thereof upon request;

2.24.4.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and

2.24.4.2.3.4 Performance goals to assess the quality of medical record keeping.

2.24.4.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.

2.24.4.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

2.25 MONITORING

2.25.1 General

2.25.1.1 TENNCARE, in its daily activities, shall monitor the CONTRACTOR for compliance with the provisions of this Agreement.

2.25.1.2 TENNCARE, CMS, or their representatives shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Monitoring activities shall include, but not be limited to, inspection of the CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. TENNCARE will emphasize case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes.

2.25.1.3 TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

2.25.2 **Facility Inspection**

TENNCARE, CMS, or their representatives may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the CONTRACTOR in fulfilling the obligations under this Agreement. Inspections may be made at anytime during the Agreement period and without prior notice.

2.25.3 **Inspection of Work Performed**

TENNCARE, CMS, or their representatives shall, at all reasonable times, have the right to enter into the CONTRACTOR's premises, or such other places where duties of this Agreement are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The CONTRACTOR and all other subcontractors or providers must supply reasonable access to all facilities and assistance for TENNCARE's representatives. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

2.25.4 **Approval Process**

2.25.4.1 As specified by TENNCARE, TENNCARE must approve various deliverables/items before they can be implemented by the CONTRACTOR.

2.25.4.2 At any time that approval of TENNCARE is required in this Agreement, such approval shall not be considered granted unless TENNCARE issues its approval in writing.

2.25.4.3 The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables (see Attachment VIII), deliverable instructions, submission and approval time frames, and technical assistance as required.

2.25.4.4 Should TENNCARE not respond to a submission of a deliverable in the amount of time agreed to by TENNCARE and the CONTRACTOR, the CONTRACTOR shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or withholds shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the item if it is determined by TENNCARE to be in the best interest of the TennCare program.

2.25.5 **Availability of Records**

2.25.5.1 The CONTRACTOR shall ensure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Comptroller of the Treasury personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit (MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to TennCare enrollees.

2.25.5.2 The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the MFCU, DOJ and the DHHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. The CONTRACTOR shall send all records to be sent by mail to TENNCARE within twenty (20) business days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the MFCU, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.

2.25.5.3 The CONTRACTOR and any of its subcontractors, providers or any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, MFCU, DHHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

2.25.5.4 The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

2.25.5.4.1 Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or subcontractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller and any duly authorized governmental agency, including federal agencies; and

2.25.5.4.2 Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

2.25.5.5 The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified person or organization to conduct the audits.

2.25.6 **Audit Requirements**

The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section 2.20 of this Agreement. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, OIG, MFCU, DOJ and the DHHS OIG, and Comptroller personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location in Tennessee subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE.

2.25.7 **Independent Review of the CONTRACTOR**

2.25.7.1 The CONTRACTOR shall cooperate fully with TENNCARE's External Quality Review Organization (EQRO) which will conduct a periodic and/or an annual independent review of the CONTRACTOR.

2.25.7.2 The CONTRACTOR shall cooperate fully with any evaluation of the TennCare program conducted by CMS.

2.25.8 **Accessibility for Monitoring**

For purposes of monitoring under this Agreement, the CONTRACTOR shall make available to TENNCARE or its representative and other authorized state and federal personnel, all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the MCO. The monitoring shall occur periodically during the Agreement period and may include announced or unannounced visits, or both.

2.25.9 **Corrective Action Requirements**

2.25.9.1 If TENNCARE determines that the CONTRACTOR is not in compliance with one or more requirements of this Agreement, TENNCARE will issue a notice of deficiency identifying the deficiency(ies), follow-up recommendations/requirements (e.g., a request for a corrective action plan), and time frames for follow-up.

2.25.9.2 Upon receipt of a notice of deficiency(ies) from TENNCARE, the CONTRACTOR shall comply with all recommendations/requirements made in writing by TENNCARE within the time frames specified by TENNCARE.

2.25.9.3 The CONTRACTOR shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the Agreement.

2.26 SUBCONTRACTS

2.26.1 **Subcontract Relationships and Delegation**

If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

2.26.1.1 The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

2.26.1.3 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;

2.26.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and

2.26.1.5 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2.12 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

2.26.2 **Legal Responsibility**

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the MCO covered thereunder including all subcontracts/subcontractors. The CONTRACTOR shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Agreement without prior written approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the

legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out in compliance with the Agreement.

2.26.3 **Prior Approval**

All subcontracts, as defined in Section 1 of this Agreement, and revisions thereto shall be approved in advance in writing by TENNCARE. The CONTRACTOR shall revise subcontracts as directed by TENNCARE. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to TENNCARE within thirty (30) calendar days of execution. This written prior approval requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 2.

2.26.4 **Subcontracts for Behavioral Health Services**

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall comply with the requirements in Section 2.9.5.2 regarding coordination of physical health and behavioral health services.

2.26.5 **Standards**

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Agreement. This includes, but is not limited to, Sections 2.19, 2.21.6, 2.25.5, 2.25.6, 2.25.8, 2.25.9, 4.3, 4.19, 4.31, and 4.32 of this Agreement.

2.26.6 **Quality of Care**

If the subcontract is for the purpose of securing the provision of covered services, the subcontract must specify that the subcontractor adhere to the quality requirements the CONTRACTOR is held to.

2.26.7 **Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions**

The CONTRACTOR shall provide instruction for all direct service subcontractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.26.8 **Children in State Custody**

The CONTRACTOR must include in its subcontracts a provision stating that subcontractors are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral health services covered by TENNCARE.

2.26.9 **Assignability**

Transportation and claims processing subcontracts must include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State's discretion upon written notice to the CONTRACTOR and the affected

subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.10 **Claims Processing**

2.26.10.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR must be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.10.2 As required in Section 2.30.18 of this Agreement, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations.

2.26.11 **HIPAA Requirements**

The CONTRACTOR shall require all its subcontractors to adhere to HIPAA requirements.

2.26.12 **Compensation for Utilization Management Activities**

Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall ensure, consistent with 42 CFR 438.210(e) that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

2.26.13 **Notice of Subcontractor Termination**

2.26.13.1 When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI.

2.26.13.2 TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

2.27.1 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity under the HIPAA regulations and agrees to comply with all applicable HIPAA regulations.

2.27.2 In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum:

2.27.2.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations;

2.27.2.2 Transmit/receive from/to its providers, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;

2.27.2.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR and its providers and/or subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Agreement in accordance with Section 4.4;

2.27.2.4 Ensure that Protected Health Information (PHI) data exchanged between the CONTRACTOR and TENNCARE is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations will be de-identified to protect the individual enrollee's PHI under the privacy act;

2.27.2.5 Ensure that disclosures of PHI from the CONTRACTOR to TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: treatment, payment, or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to TENNCARE from the CONTRACTOR shall be as permitted and/or required under the law;

2.27.2.6 Report to TENNCARE within five (5) calendar days of becoming aware of any use or disclosure of PHI in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;

2.27.2.7 Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section 2.27;

2.27.2.8 Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;

2.27.2.9 Make an enrollee's PHI data accessible to TENNCARE immediately upon request by TENNCARE;

2.27.2.10 Make available to TENNCARE within ten (10) calendar days of notice by TENNCARE to the CONTRACTOR such information as in the CONTRACTOR's possession and is required for TENNCARE to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, the CONTRACTOR shall provide TENNCARE with the following information:

2.27.2.10.1 The date of disclosure;

2.27.2.10.2 The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person;

2.27.2.10.3 A brief description of the PHI disclosed, and

2.27.2.10.4 A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

2.27.2.11 In the event that the request for an accounting of disclosures is submitted directly to the CONTRACTOR, the CONTRACTOR shall within two (2) business days forward such request to TENNCARE. It shall be TENNCARE's responsibility to prepare and deliver any such accounting requested. Additionally, the CONTRACTOR shall institute an appropriate record keeping process and procedures and policies to enable the CONTRACTOR to comply with the requirements of this Section;

2.27.2.12 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.

2.27.2.13 Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:

2.27.2.13.1 Use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI the CONTRACTOR creates, receives, maintains, or transmits on behalf of TENNCARE.

2.27.2.13.2 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.

2.27.2.13.3 Agree to report to TENNCARE's privacy officer as soon as possible but within two (2) business days any unauthorized use or disclosure of enrollee PHI not otherwise permitted or required by HIPAA. Such immediate report shall include any security incident of which the CONTRACTOR becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained by the CONTRACTOR. The CONTRACTOR shall also notify TENNCARE's privacy

officer within two (2) business days of any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the CONTRACTOR's system.

2.27.2.14 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections 2.21.6 and 2.25.6 of this Agreement the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which can not feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

2.27.2.15 Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164;

2.27.2.16 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;

2.27.2.17 Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint;

2.27.2.18 Provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;

2.27.2.19 Track training of CONTRACTOR staff and maintain signed acknowledgements by staff of the CONTRACTOR's HIPAA policies;

2.27.2.20 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations;

2.27.2.21 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;

2.27.2.22 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization;

2.27.2.23 Continue to protect personally identifiable information relating to individuals who are deceased;

2.27.2.24 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;

2.27.2.25 Make available PHI in accordance with 45 CFR 164.524;

2.27.2.26 Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526; and

2.27.2.27 Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

2.27.3 The CONTRACTOR shall track all security incidents as defined by HIPAA, and, as required by Section 2.30.19, the CONTRACTOR shall periodically report in summary fashion such security incidents (see Section 2.30.19). The CONTACTOR shall notify TENNCARE's privacy officer within two (2) business days of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.

2.27.4 TENNCARE and the CONTRACTOR are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of CONTRACTOR's information system, as defined by TCA 47-18-2107, the CONTRACTOR shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include but not be limited to mailing notifications to affected members. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with TENNCARE's express written approval.

2.27.5 In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:

2.27.5.1 Make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations;

2.27.5.2 Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight;

2.27.5.3 Adopt a mechanism for resolving any issues of non-compliance as required by law; and

2.27.5.4 Establish similar HIPAA data partner agreements with its subcontractors and other business associates.

2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

2.28.1 The CONTRACTOR shall comply with Section 4.32 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.

2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding non-discrimination activities.

2.28.3 The CONTRACTOR shall develop written policies and procedures for non-discrimination in the provision of services to persons with Limited English Proficiency, including but not limited to the provision of language interpretation and translation services for any member who needs such services as required in Section 2.18.2.

2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.

2.28.5 The CONTRACTOR shall ask all staff to provide their race or ethnic origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.

2.28.6 The CONTRACTOR shall ask all providers for their race or ethnic origin. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

2.28.7 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the TennCare program), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare MCO. The CONTRACTOR shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; CONTRACTOR's resolution, if resolved; and name of CONTRACTOR staff person responsible for adjudication of the complaint.

2.28.8 The CONTRACTOR shall report on non-discrimination activities as described in Section 2.30.19.

2.29 PERSONNEL REQUIREMENTS

2.29.1 Staffing Requirements

2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Agreement.

2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. In the event of a change to any of the key staff identified in Section 2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change.

2.29.1.3 The minimum key staff requirements are listed below. Except as provided below, these positions do not require a full-time staff person; more than one function could be conducted by the same staff person.

2.29.1.3.1 A full-time administrator/project director who has clear authority over the general administration and day-to-day business activities of this Agreement;

2.29.1.3.2 A full-time Medical Director who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;

2.29.1.3.3 A full-time senior executive who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. This person shall oversee and be responsible for all behavioral health activities;

2.29.1.3.4 A full-time chief financial officer responsible for accounting and finance operations, including all audit activities;

2.29.1.3.5 A full-time staff person responsible for all CONTRACTOR information systems who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;

2.29.1.3.6 A staff person designated as the contact available after hours for the "on-call" TennCare Solutions staff to contact with service issues;

2.29.1.3.7 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person will be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

2.29.1.3.8 A full-time staff person responsible for member services, who will communicate with TENNCARE regarding member service activities;

2.29.1.3.9 A full-time staff person responsible for provider services, including all network management issues. This person shall be responsible for communicating with TENNCARE regarding provider service activities;

2.29.1.3.10 A staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement;

2.29.1.3.11 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;

2.29.1.3.12 A staff person responsible for all quality management activities. This person shall be a physician or registered nurse licensed in the State of Tennessee;

2.29.1.3.13 A staff person responsible for all appeal system resolution issues;

2.29.1.3.14 A staff person responsible for all claims management activities;

2.29.1.3.15 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;

2.29.1.3.16 A staff person responsible for all MCO case management and care coordination issues, including but not limited to, disease management activities and coordination between physical and behavioral health services;

2.29.1.3.17 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members' interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;

2.29.1.3.18 A staff person responsible for TENNderCare services;

2.29.1.3.19 A staff person responsible for working with the Department of Children's Services;

2.29.1.3.20 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;

2.29.1.3.21 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the Care Coordination Committee and the Claims Coordination Committee as described in Section 2.9.8;

2.29.1.3.22 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination; and

2.29.1.3.23 A staff person designated for interfacing and coordinating with the TDMHDD Planning and Policy Council.

2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, MCO case management and care coordination, quality management, member education and outreach, appeal system resolution, member services, provider services, claims processing, and reporting.

2.29.1.5 The CONTRACTOR shall have a sufficient number of care coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.

2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section 2.21.9.

2.29.1.7 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section 2.29.1.3. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.

2.29.1.8 The CONTRACTOR's project director, Medical Director, financial staff, member services staff, provider services staff, UM staff, appeals staff, MCO case management staff, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state locations shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.

2.29.1.9 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

2.29.2 **Licensure**

The CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law.

2.29.3 **Board of Directors**

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

2.29.4 **Employment and Contracting Restrictions**

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:

2.29.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;

2.29.4.2 Have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

2.29.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section 2.29.4.2 of this Agreement; and

2.29.4.4 Have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

2.30 REPORTING REQUIREMENTS

2.30.1 General Requirements

2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports.

2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.

2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Agreement, according to the schedule below:

DELIVERABLES		DUE DATE
Daily Reports		Within two (2) business days.
Weekly Reports		Wednesday of the following week.
Monthly Reports		20th of the following month.
Quarterly Reports		30th of the following month.
Annual Reports		Ninety (90) calendar days after the end of the calendar year
On Request Reports		Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.
Ad Hoc Reports		Within ten (10) business days from the date of the request unless otherwise specified by TENNCARE.

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE.

2.30.1.5 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.2 **Eligibility, Enrollment and Disenrollment Reports**

2.30.2.1 The CONTRACTOR shall comply with the requirements in Section 2.23.5 regarding eligibility and enrollment data exchange.

2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Capitation Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with capitation payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received a capitation payment. The CONTRACTOR shall report this information in the format prescribed by TENNCARE.

2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Capitation Payment Report* in the event it has members for whom a capitation payment has not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise. The CONTRACTOR shall report this information in the formats provided in Attachment IX, Exhibit A.

2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.

2.30.3 **Benefits/Service Requirements and Limits Reports**

The CONTRACTOR shall submit a quarterly *Service Threshold Report* in the format prescribed by TENNCARE. At minimum, the report shall include: the number of members who reached each service threshold; confirmation that all members who reached the service threshold for mandatory enrollment in MCO case management or a disease management program were enrolled; the number of members who reached the service threshold for evaluation of appropriateness for enrollment in MCO case management or disease management who were evaluated for enrollment; the number of those members evaluated who were enrolled in MCO case management or disease management (by program); and the number of those members who were evaluated but not enrolled in MCO case management or disease management by reason.

2.30.4 **Specialized Service Reports**

2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18). These reports shall be submitted in a format to be prescribed by TENNCARE.

2.30.4.2 The CONTRACTOR shall submit a quarterly *Mental Health Case Management Report* that provides information on mental health case management appointments and refusals (see Section 2.7.2.6). The minimum data elements required are identified in Attachment IX, Exhibit B.

2.30.4.3 The CONTRACTOR shall submit an annual *Supported Employment Report* that reports on the percent of SPMI adults receiving supported employment services that are gainfully employed in either part-time or full-time capacity for a continuous ninety (90) day period (defined as the number of adults receiving supported employment for a continuous ninety (90) day period divided by the number of SPMI adults receiving supported employment services during the year) and an analysis of the findings with any action or follow-up planned as a result of the findings. These reports shall be submitted in a format to be prescribed by TENNCARE.

2.30.4.4 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements listed in Attachment IX, Exhibit C. All data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and shall be reported for each individual crisis service provider. This report shall be provided in a standardized format as specified by the State.

2.30.4.5 The CONTRACTOR shall submit a monthly *Member CRG/TPG Assessment Report* that contains information regarding the CRG assessments and TPG assessments (see Section 2.7.2.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. The CONTRACTOR shall provide this report in the format prescribed by the State. The minimum data elements required are identified in Attachment IX, Exhibit D of this Agreement.

2.30.4.6 On a quarterly basis the CONTRACTOR shall submit a *Rejected CRG/TPG Assessments Report* that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments. This report shall be submitted in the format specified by TENNCARE.

2.30.4.7 The CONTRACTOR shall submit an annual *CRG/TPG Assessments Audit Report*. The report shall contain the results of the CONTRACTOR's audits for the prior year of CRG/TPG assessments for accuracy and conformity to state policies and procedures and shall be submitted in the format prescribed by TENNCARE.

2.30.4.8 The CONTRACTOR shall annually submit to TENNCARE its methodology for conducting the CRG/TPG assessment audits on March 1.

2.30.4.9 The CONTRACTOR shall submit a quarterly *Health Education/Outreach Report* which provides information on the programs and activities the CONTRACTOR has conducted in the areas of health education and outreach during the previous quarter. (See Section 2.7.3). The report shall be submitted in a format specified by TENNCARE.

2.30.4.10 The CONTRACTOR shall submit a quarterly *TENNderCare Report* in a format specified by TENNCARE.

2.30.5 **Disease Management Reports**

2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.

2.30.5.2 The CONTRACTOR shall submit 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 active 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, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7. The report shall be submitted in a format prescribed by TENNCARE.

2.30.6 **Service Coordination Reports**

2.30.6.1 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report* that includes a brief narrative description of the MCO case management program (see Section 2.9.4); the total number of members enrolled in the MCO case management program; number of members enrolled and disenrolled in the program during the quarter; member selection criteria; the number of members who declined case management services; a description of services provided during the quarter and an evaluation of the impact of the MCO case management program during the quarter. The CONTRACTOR shall submit these reports in a format prescribed by TENNCARE.

2.30.6.2 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.7).

2.30.6.3 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.

2.30.6.4 The CONTRACTOR shall submit a *Pharmacy Services Report, On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.7 **Provider Network Reports**

2.30.7.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical and behavioral health providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, and emergency and non-emergency transportation providers. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. The report shall be sorted by provider type. The CONTRACTOR shall submit this report in the format to be prescribed by TENNCARE. The CONTRACTOR shall submit this report during readiness review, by the 5th of each month, and upon TENNCARE request. Each monthly *Provider Enrollment File* shall include information on all providers of TennCare health services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

2.30.7.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards. (See Section 2.11.1.10.)

2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides information on members not assigned to a primary care provider (PCP) within thirty (30) calendar days of enrollment or prior to the member's beginning effective date. This report shall be submitted using the format provided in Attachment IX, Exhibit F. (See Section 2.11.2.)

2.30.7.4 The CONTRACTOR shall submit an annual *Report of Essential Hospital Services* by September 1 of each year. The CONTRACTOR shall use the format in Attachment IX, Exhibit G.

2.30.7.5 The CONTRACTOR shall submit a quarterly *Behavioral Health Initial Appointment Timeliness Report* that shall include the average time between the intake assessment appointment and the member's next scheduled appointment or admission. The report shall provide this information by type of service and shall include an analysis of the findings and any actions or follow-up planned as a result of the findings. The report shall be submitted in a format prescribed by TENNCARE.

2.30.7.6 The CONTRACTOR shall submit an annual *FQHC Report* by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment IX, Exhibit H.

2.30.8 **Provider Agreement Report**

The CONTRACTOR shall submit a monthly *Single Case Agreements Report* using the format provided in Attachment IX, Exhibit I. (See Section 2.12.4.)

2.30.9 **Provider Payment Report**

The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.14.)

2.30.10 **Utilization Management Reports**

2.30.10.1 The CONTRACTOR shall submit its UM program policies and procedures, the annual evaluation (which includes an analysis of findings and actions taken) and the work plan approved by the CONTRACTOR's oversight committee to TENNCARE on April 15 of each year.

2.30.10.2 The CONTRACTOR shall submit a semi-annual *ED Utilization Report* (see Section 2.14.1.11) in a format to be specified by TENNCARE.

2.30.10.3 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be submitted using the format provided in Attachment IX, Exhibit J. These reports shall be in an Excel spreadsheet format and submitted within seventy-five (75) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

2.30.10.4 The CONTRACTOR shall provide quarterly *Cost and Utilization Summaries*. These summaries shall report on services paid during the previous quarter. The summaries shall be submitted in a format specified by TENNCARE and shall include all data elements listed in Attachment IX, Exhibit K.

2.30.10.5 The CONTRACTOR shall identify and report the number of members who incurred claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name of the member shall be blinded in order to maintain confidentiality.

2.30.10.6 The CONTRACTOR shall submit quarterly *Prior Authorization Reports* that include the information in Attachment IX, Exhibit L. These reports shall be submitted in the format specified in Attachment IX, Exhibit L.

2.30.10.7 The CONTRACTOR shall submit a copy of the *Referral Provider Listing* (see Section 2.14.3.5), a data file of the provider information used to create the listing in a media and format prescribed by TENNCARE, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the referral provider listings mailed to providers, the date mailed, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section 2.14.3.5.

2.30.11 **Quality Management/Quality Improvement Reports**

2.30.11.1 The CONTRACTOR shall annually submit an approved (by the CONTRACTOR's QM/QI Committee) QM/QI Program Description, Associated Work Plan, and Annual Evaluation.

2.30.11.2 The CONTRACTOR shall update and submit a quarterly *Quality Update Report.* The report shall include updates on the progress made toward scheduled activities in the QM/QI work plan and barrier analysis on the activities that have been delayed with explanation of the delays and the plan for completing any delayed scheduled activities.

2.30.11.3 The CONTRACTOR shall submit an annual *Report on Performance Improvement Projects* that includes the information specified in Section 2.15.3.

2.30.11.4 The CONTRACTOR shall submit an annual *Report of Performance Indicator Results, Audited CAHPS Results* and *Audited HEDIS Results* by June 15 of each year (see Sections 2.15.4, 2.15.6 and 2.15.7).

2.30.11.5 The CONTRACTOR shall submit its *NCQA Accreditation Report* immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA

2.30.12 **Customer Service Reports**

2.30.12.1 The CONTRACTOR shall submit a quarterly *Member Services and UM Phone Line Report.* The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter. The CONTRACTOR shall submit the report in a format to be prescribed by TENNCARE.

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement (see Section 2.18.7.2).

2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone. The data shall be reported by month in a format to be specified by TENNCARE.

2.30.13 **Fraud and Abuse Reports**

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 **Financial Management Reports**

2.30.14.1 Third Party Liability (TPL) Resources Reports

2.30.14.1.1 The CONTRACTOR shall submit a quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE and submit this report in a format specified by TENNCARE.

2.30.14.1.2 The CONTRACTOR shall submit an *Other Insurance Report* that provides information on any members who have other insurance. This report shall be submitted in a format and frequency described by TENNCARE.

2.30.14.2 Financial Reports to TENNCARE

2.30.14.2.1 The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation using the forms in Attachment IX, Exhibit N. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.16.3 and 2.23.4.

2.30.14.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.8 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

2.30.14.2.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year in a format to be prescribed by TENNCARE. (See Section 2.21.9.)

2.30.14.3 <u>TDCI Financial Reports</u>

2.30.14.3.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report.* This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Agreement. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.

2.30.14.3.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report.* If necessary, the CONTRACTOR shall revise the calendar year budget based on its actual results of operations. Any revisions to the budget must include narratives explaining the assumptions and calculations utilized in making the revisions.

2.30.14.3.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-208. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report will also be accompanied by the Medical Loss Ratio report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Loss Ratio report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).

2.30.14.3.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report.* These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before June 1 (covering first quarter of current year), September 1 (covering second quarter of current year) and December 1 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on September 1) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities

reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

2.30.14.3.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements.* Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:

2.30.14.3.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.

2.30.14.3.5.2 Any requests for extension of the May 1 submission date must be granted by the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

2.30.14.3.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

2.30.14.3.5.4 These financial reporting requirements shall supersede any other reporting requirements required of the CONTRACTOR by TDCI, and TDCI shall enact any necessary rule or regulation to conform to this provision of the Agreement.

2.30.15 **Claims Management Reports**

2.30.15.1 The CONTRACTOR shall submit a quarterly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section 2.22.6) and shall report on the number and percent of claims that are paid accurately. The numbers and percents shall be reported on a monthly basis. The report shall be submitted in a format prescribed by TENNCARE.

2.30.15.2 The CONTRACTOR shall submit a quarterly *Explanation of Benefits* (*EOB) Report*. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section 2.22.8.)

2.30.16 **Information Systems Reports**

2.30.16.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section 2.23.1.6.

2.30.16.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section 2.23.4) and transmitted electronically to TENNCARE on a weekly basis.

2.30.16.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section 2.30.14.2.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the MLR report.

2.30.16.4 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.

2.30.16.5 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the CONTRACTOR's span of control.

2.30.16.6 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and approval as specified by TENNCARE. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and approval by TENNCARE.

2.30.17 **Administrative Requirements Reports**

The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee* regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year according to the format specified by the State.

2.30.18 **Subcontract Reports**

2.30.18.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.

2.30.18.2 In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably

designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

2.30.18.2.1 *General Controls*

2.30.18.2.1.1 Personnel Policies

2.30.18.2.1.2 Segregation of Duties

2.30.18.2.1.3 Physical Access Controls

2.30.18.2.1.4 Hardware and System Software

2.30.18.2.1.5 Applications System Development and Modifications

2.30.18.2.1.6 Computer Operations

2.30.18.2.1.7 Data Access Controls

2.30.18.2.1.8 Contingency and Business Recovery Planning

2.30.18.2.2 *Application Controls*

2.30.18.2.2.1 Input

2.30.18.2.2.2 Processing

2.30.18.2.2.3 Output

2.30.18.2.2.4 Documentation Controls

2.30.19 **HIPAA Reports**

The CONTRACTOR shall submit a Security Incident Report in a format to be prescribed by TENNCARE. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. “Port scans” or other unsuccessful queries to the CONTRACTOR’s information system shall not be considered a security incident for purposes of this report.

2.30.20 **Non-Discrimination Compliance Reports**

2.30.20.1 The CONTRACTOR shall submit an annual *Summary Listing of Servicing Providers* that includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race or ethnic origin and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The CONTRACTOR shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian

or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by TENNCARE.

2.30.20.2 The CONTRACTOR shall submit a quarterly *Supervisory Personnel Report* that contains a summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE.

2.30.20.3 The CONTRACTOR shall submit a quarterly *Alleged Discrimination Report*. The report shall include a listing of all complaints alleging discrimination filed by employees, members, providers and subcontractors in which discrimination is alleged by the CONTRACTOR's MCO. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint.

2.30.20.4 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in provision of services to members with Limited English Proficiency. This shall include a listing of interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency. The listing shall provide the full name of the interpreter/translator service, address, phone number, and hours services are available.

2.30.20.5 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan* and *Assurance of Non-Discrimination* to TENNCARE in a format to be prescribed by TENNCARE. The signature date of the CONTRACTOR's Title VI Compliance Plan shall coordinate with the signature date of the CONTRACTOR's Assurance of Non-Discrimination.

2.30.21 Terms and Conditions Reports

Quarterly, by January 30, April 30, July 30, and October 30 each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section 4.19.

2.31 STATE ONLYS AND JUDICIALS

2.31.1 General

2.31.1.1 As specified in this Section 2.31, the CONTRACTOR shall provide medically necessary covered behavioral health services (see Sections 2.6 and 2.7) to State Onlys and Judicials (as defined in Section 1).

2.31.1.2 Judicials are only entitled to coverage of those behavioral health evaluation and treatment services required by state law (see Section 2.7.2.10.2) or by the court order under which the individual was referred.

2.31.1.3 State Onlys are entitled to all medically necessary covered behavioral health services.

2.31.1.4 TENNCARE shall provide pharmacy services related to behavioral health diagnoses.

2.31.1.5 Neither State Onlys nor Judicials are entitled to covered physical health services.

2.31.1.6 The requirements of this Agreement shall apply to State Onlys and Judicials as specified below. When a section/requirement applies to State Onlys and/or Judicials, the terms "TennCare enrollee," "enrollee," and/or "member" referenced in the requirement/section shall be read to include State Onlys and Judicials.

2.31.2 **Applicability of Agreement**

2.31.2.1 Section 2.1, REQUIREMENTS PRIOR TO OPERATIONS, shall apply to State Onlys and Judicials.

2.31.2.2 Section 2.2, GENERAL REQUIREMENTS, shall apply to State Onlys and Judicials.

2.31.2.3 Section 2.3, ELIGIBILITY, is not applicable to State Onlys and Judicials. However, as provided in Section 2.3.4, the State shall have sole responsibility for determining the eligibility of a Judicial or State Only. State Onlys and Judicials are not subject to any cost sharing.

2.31.2.4 Section 2.4, ENROLLMENT, applies to State Onlys and Judicials as follows:

2.31.2.4.1 Section 2.4.1, General, applies to State Onlys and Judicials. TENNCARE is solely responsible for enrollment of State Onlys and Judicials in an MCO.

2.31.2.4.2 Section 2.4.2, Authorized Service Area, applies to State Onlys and Judicials. State Onlys and Judicials will be enrolled by Grand Region, and the CONTRACTOR is only authorized to serve State Onlys and Judicials residing in a county included in the Grand Region served by the CONTRACTOR.

2.31.2.4.3 Section 2.4.3, Maximum Enrollment shall apply to State Onlys and Judicials.

2.31.2.4.4 Except for Section 2.4.4.7, Non-Discrimination, Section 2.4.4, MCO Selection and Assignment, does not apply to State Onlys and Judicials. The State will assign State Onlys and Judicials to MCOs on a random basis that ensures similar levels of enrollment for the MCOs serving a Grand Region. Section 2.4.4.7, Non-Discrimination, shall apply to State Onlys and Judicials.

2.31.2.4.5 In Section 2.4.5, Effective Date of Enrollment, Sections 2.4.5.1 through 2.4.5.3 do not apply to State Onlys and Judicials. However, as with TennCare enrollees, the effective date of enrollment in the CONTRACTOR's MCO shall be the date provided on the enrollment file from TENNCARE. State Onlys and Judicials can be retroactively eligible to the date of application. Section 2.4.5.4, Enrollment Prior to Notification, applies to State Onlys and Judicials.

2.31.2.4.6 Section 2.4.6, Eligibility and Enrollment Data, shall apply to State Onlys and Judicials. They shall be included in eligibility and enrollment data.

2.31.2.4.7 In Section 2.4.7, Enrollment Period, Section 2.4.7.1, General, and Section 2.4.7.3, Member Moving out of Grand Region, shall apply to State Onlys and Judicials. Section 2.4.7.2, Changing MCOs, shall not apply. State Onlys and Judicials will not be given the opportunity to change MCOs.

2.31.2.4.8 Section 2.4.8, Transfers from Other MCOs, shall apply to State Onlys and Judicials.

2.31.2.4.9 Section 2.4.9, Enrollment of Newborns, shall not apply to State Onlys and Judicials.

2.31.2.4.10 Section 2.4.10, Information Requirements Upon Enrollment, shall not apply to State Onlys and Judicials.

2.31.2.5 In Section 2.5, DISENROLLMENT FROM AN MCO, Section 2.5.1, General, shall apply to State Onlys and Judicials. Sections 2.5.2 through 2.5.5 shall not apply to State Onlys and Judicials. As with TennCare enrollees, TENNCARE shall be responsible for disenrolling State Onlys and Judicials, and the effective date of disenrollment shall be indicated on the termination record.

2.31.2.6 Section 2.6, BENEFITS/SERVICE REQUIREMENTS AND LIMITATIONS, shall apply as follows:

2.31.2.6.1 In Section 2.6.1, CONTRACTOR Covered Benefits, Section 2.6.1.2, CONTRACTOR Physical Health Benefits Chart, shall not apply. The CONTRACTOR is not responsible for providing physical health services to State Onlys and Judicials. Section 2.6.1.4, CONTRACTOR Behavioral Health Benefits Chart, shall apply. However, for Judicials the CONTRACTOR is only required to provide the behavioral health evaluation and treatment services required by state law (see Section 2.7.2.10.2) or by the court order under which the individual was referred.

2.31.2.6.2 In Section 2.6.2, TennCare Benefits Provided by TENNCARE, only Section 2.6.2.2, Pharmacy Services, shall apply to State Onlys and Judicials. TENNCARE will cover certain pharmacy services for the treatment of behavioral health disorders for State Onlys and Judicials. The CONTRACTOR shall be responsible for the related laboratory expenses.

2.31.2.6.3 In Section 2.6.3, Medical Necessity Determination, Sections 2.6.3.1 through 2.6.3.4 shall apply to State Onlys and Judicials. Section 2.6.3.5 shall not apply to State Onlys and Judicials.

2.31.2.6.4 Section 2.6.4, Second Opinions, shall not apply to State Onlys and Judicials.

2.31.2.6.5 Section 2.6.5, Use of Cost Effective Alternative Services, shall apply to State Onlys and Judicials.

2.31.2.6.6 Section 2.6.6, Additional Services and Use of Incentives, shall apply to State Onlys and Judicials.

2.31.2.6.7 In Section 2.6.7, Cost Sharing for Services, only Section 2.6.7.1, General, shall apply to State Onlys and Judicials. There is no cost sharing required for State Onlys and Judicials.

2.31.2.7 Section 2.7, SPECIALIZED SERVICES, shall apply as follows:

2.31.2.7.1 Section 2.7.1, Emergency Services, shall not apply to State Onlys and Judicials. However, behavioral health crisis services are covered for State Onlys and Judicials (see Section 2.31.7.2.8).

2.31.2.7.2 Section 2.7.2, Behavioral Health Services, shall apply to State Onlys and Judicials. However, Sections 2.7.2.10.2.5 and 2.7.2.10.2.6, regarding voluntary hospital admissions, shall not apply to Judicials.

2.31.2.7.3 Section 2.7.3, Health Education and Outreach, shall not apply to State Onlys and Judicials.

2.31.2.7.4 Section 2.7.4, Preventive Services, shall not apply to State Onlys and Judicials.

2.31.2.7.5 Section 2.7.5, TENNderCare, shall not apply to State Onlys and Judicials.

2.31.2.7.6 Section 2.7.6, Advance Directives, shall not apply to State Onlys and Judicials.

2.31.2.7.7 Section 2.7.8, Sterilizations, Hysterectomies and Abortions, shall not apply to State Onlys and Judicials.

2.31.2.8 Section 2.8, DISEASE MANAGEMENT, shall apply to State Onlys and Judicials for the three behavioral health conditions (bipolar disorder, major depression, and schizophrenia). State Onlys and Judicials are not eligible for the physical health disease management programs.

2.31.2.9 Section 2.9, SERVICE COORDINATION, shall apply as follows:

2.31.2.9.1 Section 2.9.1, General, shall not apply to State Onlys and Judicials.

2.31.2.9.2 Section 2.9.2, Transition of New Members, shall not apply to State Onlys and Judicials.

2.31.2.9.3 Section 2.9.3, Transition of Care, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.9.4 Section 2.9.4, MCO Case Management, shall apply to State Onlys and Judicials relative to covered behavioral health services.

2.31.2.9.5 Section 2.9.5, Coordination and Collaboration Between Physical Health and Behavioral Health, shall not apply to State Onlys and Judicials.

2.31.2.9.6 Section 2.9.6, Coordination and Collaboration Among Behavioral Health Providers, shall apply to State Onlys and Judicials.

2.31.2.9.7 Section 2.9.7, Coordination of Pharmacy Services, shall apply to State Onlys and Judicials for pharmacy services related to behavioral health diagnoses.

2.31.2.9.8 Section 2.9.8, Coordination of Dental Benefits, shall not apply to State Onlys and Judicials.

2.31.2.9.9 Section 2.9.9, Coordination with Medicare, shall apply to State Onlys and Judicials to the extent applicable for covered behavioral health services.

2.31.2.9.10 Section 2.9.10, Institutional Services and Alternatives to Institutional Services, shall not apply to State Onlys and Judicials.

2.31.2.9.11 Section 2.9.11, Inter-Agency Coordination, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.10 Section 2.10, SERVICES NOT COVERED, shall apply to State Onlys and Judicials.

2.31.2.11 Section 2.11, PROVIDER NETWORK, shall apply as follows:

2.31.2.11.1 Section 2.11.1, General Provisions, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.11.2 Section 2.11.2, Primary Care Providers (PCPs), shall not apply to State Onlys and Judicials.

2.31.2.11.3 Section 2.11.3, Specialty Service Providers, shall apply to State Onlys and Judicials for Centers of Excellence for Behavioral Health and for psychiatry.

2.31.2.11.4 Section 2.11.4, Special Conditions for Prenatal Care Providers, shall not apply to State Onlys and Judicials

2.31.2.11.5 Section 2.11.5, Special Conditions for Behavioral Health Services, shall apply to State Onlys and Judicials.

2.31.2.11.6 In Section 2.11.6, Safety Net Providers, Section 2.11.6.2, Community Mental Health Agencies, shall apply to State Onlys and Judicials. The other sections shall not apply to State Onlys and Judicials.

2.31.2.11.7 Section 2.11.7, Credentialing and Other Certification, shall apply to State Onlys and Judicials for behavioral health providers.

2.31.2.11.8 Section 2.11.8, Network Notice Requirements, shall not apply to State Onlys and Judicials.

2.31.2.12 Except as provided below, Section 2.12, PROVIDER AGREEMENTS, shall apply to State Onlys and Judicials. The following sections do not apply to State Onlys and Judicials:

2.31.2.12.1 The first sentence of Section 2.12.7.6, regarding services to children;

2.31.2.12.2 Section 2.12.7.10 regarding delay in providing prenatal care;

2.31.2.12.3 Section 2.12.7.29, regarding cost sharing;

2.31.2.12.4 Section 2.12.7.42, regarding emergency appeals;

2.31.2.12.5 Section 2.12.7.46, regarding TENNderCare;

2.31.2.12.6 Section 2.12.7.50, regarding disclosure of information; and

2.31.2.12.7 Section 2.12.9, regarding contracts with local health departments.

2.31.2.13 Section 2.13, PROVIDER AND SUBCONTRACTOR PAYMENTS, shall apply to State Onlys and Judicials for covered behavioral health services provided by behavioral health providers and subcontractors. Section 2.13.2, Hospice, Section 2.13.4, Local Health Departments, and Section 2.13.13, Transition of New Members, shall not apply to State Onlys and Judicials.

2.31.2.14 Section 2.14, UTILIZATION MANAGEMENT (UM), shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.15 Section 2.15, QUALITY MANAGEMENT, shall apply to State Onlys and Judicials for behavioral health services. However, State Onlys and Judicials shall not be included in the CONTRACTOR's behavioral health performance improvement project.

2.31.2.16 Section 2.16, MARKETING, shall apply to State Onlys and Judicials. The CONTRACTOR shall not conduct any marketing activities.

2.31.2.17 Section 2.17, MEMBER MATERIALS, shall not apply to State Onlys and Judicials. Member materials are not to be sent to State Onlys and Judicials.

2.31.2.18 Section 2.18, CUSTOMER SERVICE, shall apply to State Onlys and Judicials as it relates to covered behavioral health services.

2.31.2.19 Section 2.19, COMPLAINTS AND APPEALS, shall not apply to State Onlys and Judicials. State Onlys and Judicials do not have appeal rights; however, they shall have the right to file complaints with the CONTRACTOR.

2.31.2.20 Section 2.20, FRAUD AND ABUSE, shall apply to State Onlys and Judicials.

2.31.2.21 Section 2.21, FINANCIAL MANAGEMENT, shall apply to State Onlys and Judicials.

2.31.2.22 Section 2.22, CLAIMS MANAGEMENT, shall apply to State Onlys and Judicials for payment of behavioral health providers.

2.31.2.23 Section 2.23, INFORMATION SYSTEMS, shall apply to State Onlys and Judicials.

2.31.2.24 Section 2.24, ADMINISTRATIVE REQUIREMENTS, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.25 Section 2.25, MONITORING, shall apply to State Onlys and Judicials.

2.31.2.26 Section 2.26, SUBCONTRACTS, shall apply to State Onlys and Judicials.

2.31.2.27 Section 2.27, COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), shall apply to State Onlys and Judicials.

2.31.2.28 Section 2.28, NON-DISCRIMINATION COMPLIANCE REQUIREMENTS, shall apply to State Onlys and Judicials.

2.31.2.29 Section 2.29, PERSONNEL REQUIREMENTS, shall apply to State Onlys and Judicials.

2.31.2.30 Section 2.30 REPORTING REQUIREMENTS, shall apply to State Onlys and Judicials. State Onlys and Judicials shall be included in reports provided to TENNCARE and TDCI.

2.31.2.31 Section 3, PAYMENTS TO THE CONTRACTOR, shall apply to State Onlys and Judicials.

2.31.2.32 Section 4, TERMS AND CONDITIONS, shall apply to State Onlys and Judicials. However, in 4.3, Applicable Laws and Regulations, requirements specific to Medicaid or the TennCare program (e.g., federal Medicaid law and regulations, the TennCare waiver) shall not apply to State Onlys and Judicials. Also, liquidated damages specific to the TennCare program or physical health services shall not apply to State Onlys and Judicials. Other liquidated damages, including liquidated damages related to behavioral health services, shall apply to State Onlys and Judicials.

SECTION 3 - PAYMENTS TO THE CONTRACTOR

3.1 GENERAL PROVISIONS

3.1.1 TENNCARE shall make monthly payments to the CONTRACTOR for its satisfactory performance and provision of covered services under this Agreement. Capitation rates shall be paid according to the methodology as described in this Agreement.

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1 and any incentive payments (if applicable) are payment in full for all services provided pursuant to this Agreement. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

3.2 ANNUAL ACTUARIAL STUDY

In accordance with TCA 9-9-101, the State shall retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE in order to assist the State's actuary with completion of the annual actuarial study.

3.3 CAPITATION PAYMENT RATES

3.3.1 The CONTRACTOR will be paid a base capitation rate for each enrollee based on the enrollee's category of aid and age/sex combination and the Grand Region served by the CONTRACTOR under this Agreement in accordance with the rates specified in Attachment X.

3.3.2 The major aid categories are as follows:

3.3.2.1 Medicaid;

3.3.2.2 Uninsured/Uninsurable;

3.3.2.3 Disabled - The disabled rate is only for those enrollees who are eligible for Medicaid as a result of a disability;

3.3.2.4 Medicaid/Medicare Duals - For the purpose of capitation rates, Medicaid/Medicare dual enrollees are TennCare Medicaid enrollees who have Medicare eligibility; and

3.3.2.5 Waiver/Medicare Duals - For the purpose of capitation rates, Waiver/Medicare dual enrollees are TennCare Standard enrollees who have Medicare eligibility.

3.3.3 The CONTRACTOR will also be paid a priority add-on rate for behavioral health services in accordance with the rates specified in Attachment X for each priority enrollee. The CONTRACTOR will be paid the priority add-on rate for priority enrollees, as defined in this Agreement, who have received behavioral health services as reported pursuant to Section 2.23.4 of this Agreement, within the preceding twelve (12) months from the date of the calculation of the monthly payment, and who have had a valid CRG/TPG assessment within the preceding twelve (12) months from the date of the calculation of the monthly payment.

3.3.4 The CONTRACTOR will be paid the rates specified in Attachment X for State Onlys and Judicials. The capitation rate for State Onlys and Judicials shall be for behavioral health services only.

3.3.5 TENNCARE will determine the appropriate rate category to which each enrollee is assigned for payment purposes under this Agreement.

3.3.6 TENNCARE's assignment of an enrollee to a rate category is for payment purposes under this Agreement, only, and is not an "adverse action" or determination of the benefits to which an enrollee is entitled under the TennCare program, TennCare rules and regulations, TennCare policies and procedures, the TennCare waiver or relevant court orders or consent decrees.

3.4 CAPITATION RATE ADJUSTMENT

3.4.1 The CONTRACTOR and TENNCARE agree that the capitation rates described in Section 3 of this Agreement may be adjusted periodically.

3.4.2 The CONTRACTOR and TENNCARE further agree that adjustments to capitation rates shall occur only by written amendment to this Agreement.

3.4.3 The following shall be applicable to adjusting the base capitation rate only:

3.4.3.1 The CONTRACTOR agrees to accept the base capitation rates originally proposed by the CONTRACTOR adjusted by the State for health plan risk in accordance with the following:

3.4.3.2 Health plan risk assessment scores will be initially recalibrated after current TennCare enrollees are assigned to the MCOs for retroactive application to payment rates effective on the start date of operations.

3.4.3.2.1 This initial recalibration will be based upon the distribution of enrollment on the start date of operations and health status information will be 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.

3.4.3.2.2 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 proposed by all MCOs will be proportionally adjusted.

3.4.3.3 Thereafter, 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 region being served by the MCO by more than three percent (3%), whether a negative or positive change in scores, the base capitation rates originally proposed by all MCOs as subsequently adjusted will be proportionally adjusted.

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, defined as a change of three percent (3%) or more, whether a negative or positive change in scores, TENNCARE may adjust the base capitation rates originally proposed by all MCOs as subsequently adjusted for all MCOs.

3.4.3.5 In addition to the annual recalibration of risk adjustment factors, those factors will be updated when there is a significant change in program participation. This may occur when an MCO enters or leaves a Grand Region. If an MCO withdraws from a Grand Region, that MCO's membership may be temporarily distributed to TennCare Select or distributed to the remaining MCOs or to new MCOs. New risk adjustment values for the remaining MCOs or new MCO(s) will be calculated that consider the population that will be enrolled in the MCO for the remainder of the contract year only. In this instance, MCOs would be given the option to provide TENNCARE, in writing, with a six (6) months notice of termination in accordance with Section 4.4.6.2. This notice option is not available for rate adjustments as described in Sections 3.4.3.1 through 3.4.3.4.

3.4.3.6 An individual's health status will be determined using the John Hopkins ACG® Case-Mix System (ACG System). In the event the State elects to use a different system to calculate an adjustment for MCO health status risk, the State will notify the CONTRACTOR prior to its implementation.

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 originally proposed by the CONTRACTOR as subsequently adjusted and the priority add-on rates and State Only and Judicials rates originally specified by the State shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

3.4.5 If (i) changes are required pursuant to federal or state statute, federal regulations, the action of a federal agency, a state or federal court, or rules and regulations of a State of Tennessee agency other than the TennCare Bureau and (ii) the changes are likely to impact the actuarial soundness of the capitation rate(s) described in Section 3, as determined by TENNCARE, TENNCARE shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.6 In the event TENNCARE amends TennCare rules or regulations or initiates a policy change not addressed in Section 3.4.5 above that is likely to impact the capitation rate(s) described in Section 3, as determined by TENNCARE, TENNCARE shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.7 In the event TENNCARE requires that the CONTRACTOR contract with the transportation vendor selected by the State, TENNCARE shall have its independent actuary determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.8 In the event the amount of the two percent (2%) premium tax is increased during the term of this Agreement, the payments shall be increased by an amount equal to the increase in premium payable by the CONTRACTOR.

3.4.9 Any rate adjustments shall be subject to the availability of state appropriations.

3.5 CAPITATION PAYMENT SCHEDULE

TENNCARE shall make payment by the fifth (5th) business day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement.

3.6 CAPITATION PAYMENT CALCULATION

When eligibility has been established by the State for enrollees, the amount owed to the CONTRACTOR shall be calculated as described herein and the amount due the CONTRACTOR shall be included in the current month payment of the capitation rate.

3.6.1 Each month payment to the CONTRACTOR shall be equal to the number of enrollees enrolled in the CONTRACTOR's MCO five (5) business days prior to the date of the capitation payment multiplied by the appropriate capitation rate(s) for the enrollee.

3.6.2 The capitation rates stated in Attachment X will be the amounts used to determine the amount of the monthly capitation payment.

3.6.3 The actual amount owed the CONTRACTOR for each member shall be determined by dividing the appropriate monthly capitation rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the CONTRACTOR's MCO.

3.6.4 The amount paid to the CONTRACTOR shall equal the total of the amount owed for all enrollees determined pursuant to Section 3.6.3 less the withhold amount (see Section 3.9), capitation payment adjustments made pursuant to Section 3.7 or 3.10, and any other adjustments, which may include withholds for penalties, damages, liquidated damages, or adjustments based upon a change of enrollee status.

3.7 CAPITATION PAYMENT ADJUSTMENTS

3.7.1 The State has the discretion to retroactively adjust the capitation payment for any enrollee if TENNCARE determines an incorrect payment was made to the CONTRACTOR; provided, however:

3.7.1.1 For determining the capitation rate(s) only, the Grand Region being served by the enrollee's MCO under this Agreement will be used to determine payment. The

capitation payment shall not be retroactively adjusted to reflect a different Grand Region of residence so long as the enrollee's MCO assignment is effective.

3.7.1.2 For individuals enrolled with a retroactive effective date on the date of enrollment, the payment rate for retroactive periods shall be the capitation rate(s) for the applicable rate category and the Grand Region in which the enrollee's assigned MCO is operating under this Agreement as specified in Attachment X, except that:

3.7.1.2.1 The CONTRACTOR agrees to manually process claims and reimburse providers for services incurred prior to the start date of operations of this Agreement; however, the CONTRACTOR will not be at risk for these services. The CONTRACTOR shall be paid two dollars ($2.00) per claim as reimbursement for processing claims for services incurred prior to the start date of operations. Actual expenditures for covered services and the allowed amount for claims processing are subject to TCA 56-32-224. The CONTRACTOR shall negotiate provider reimbursement subject to TENNCARE prior approval and prepare checks for payment of providers for the provision of covered services incurred during an enrollee's period of eligibility prior to the start date of operations on an as needed basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and format at least forty-eight (48) hours in advance of distribution of any provider payment related to this requirement. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, two dollars ($2.00) per claim processed by the CONTRACTOR; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-224 within forty-eight (48) hours of receipt of notice. The CONTRACTOR shall then release payments to providers within twenty-four (24) hours of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-224.

3.7.1.3 If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the CONTRACTOR shall assess cost sharing responsibilities in accordance with the cost sharing schedules in effect on the date of service for which reimbursement is sought (see Attachment II).

3.7.1.4 Should TENNCARE determine after the capitation payment is made that an enrollee's capitation rate category had changed or the enrollee was deceased, TENNCARE shall retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period for which payment has been made. TENNCARE shall initially retroactively adjust the payment to the CONTRACTOR, not to exceed twelve (12) months. Subsequently, TENNCARE shall further retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period prior to the twelve (12) month adjustment initially made by TENNCARE. TENNCARE will make the subsequent adjustment at least semi-annually.

3.7.1.4.1 TENNCARE and the CONTRACTOR agree that the twelve (12) month limitation described in Sections 3.7.1.4 is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the CONTRACTOR's MCO.

3.7.1.5 Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process.

3.8 SERVICE DATES

Except where required by this Agreement or by applicable federal or state law, the CONTRACTOR shall not make payment for the cost of any services provided prior to the effective date of eligibility in the CONTRACTOR's MCO. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's MCO.

3.9 WITHHOLD OF THE CAPITATION RATE

3.9.1 A withhold of the aggregate capitation payment shall be applied to ensure CONTRACTOR compliance with the requirements of this Agreement and to provide an agreed incentive for assuring CONTRACTOR compliance with the requirements of this Agreement.

3.9.2 The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section 3.6 shall be reduced by the appropriate cash flow withhold percentage amount and set aside for distribution to the CONTRACTOR in the next regular monthly payment, unless retained as provided below.

3.9.2.1 Except as further provided below, the applicable capitation payment withhold amount will be equivalent to ten percent (10%) of the monthly capitation payment for the first six months following the start date of operations, and for any consecutive six (6) month period following the CONTRACTOR's receipt of a notice of deficiency as described in Section 2.25.9;

3.9.2.2 If, during any consecutive six (6) month period following the start date of operations, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to five percent (5%) of the monthly capitation payment.

3.9.2.3 If, during any consecutive six (6) month period following a reduction of the monthly withhold amount to five percent (5%) of the monthly capitation payment, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to two and one half percent (2.5%) of the monthly capitation payment.

3.9.2.4 If the CONTRACTOR is notified by TENNCARE of a minor deficiency and the CONTRACTOR cures the minor deficiency to the satisfaction of TENNCARE within a reasonable time prior to the next regularly scheduled capitation payment cycle, TENNCARE may disregard the minor deficiency for purposes of determining the withhold.

3.9.2.5 If TENNCARE has determined the CONTRACTOR is not in compliance with a requirement of this Agreement in any given month, TENNCARE will issue a written notice of deficiency and TENNCARE will retain the amount withheld for the month prior to TENNCARE identifying the compliance deficiencies.

3.9.2.6 The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies shall be in accordance with Section 3.9.2.1 as described above. If the CONTRACTOR has attained a two and one half

percent (2.5%) withhold and TENNCARE subsequently determines the CONTRACTOR is not in compliance with a requirement of this Agreement, TENNCARE will provide written notice of such determination and TENNCARE will re-institute the retention of the withhold as described in Section 3.9.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount will continue for each subsequent month so long as the identified deficiencies have not been corrected. These funds will not be distributed to the CONTRACTOR unless it is determined by TENNCARE the CONTRACTOR has come into compliance with the Agreement requirement(s) within six (6) months of TENNCARE identifying these deficiencies. For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies which the CONTRACTOR has been given written notice of by TENNCARE, the withhold for the four (4) consecutive months will be paid to the CONTRACTOR upon TENNCARE determination that the deficiency(s) was corrected. However, any amounts withheld by TENNCARE for six (6) consecutive months for the same or similar compliance deficiency(s) shall be retained by TENNCARE on the anniversary of the sixth consecutive month and shall not be paid to the CONTRACTOR. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TENNCARE may declare the MCO ineligible for future distribution of the ten percent (10%) incentive withhold. Such ineligibility will continue for each month TENNCARE determines the same or similar specified deficiency(s) continues to exist. Once a CONTRACTOR corrects the deficiency(s), TENNCARE may reinstate the MCO's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TENNCARE determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the CONTRACTOR.

3.9.3 No interest shall be due to the CONTRACTOR on any sums withheld or retained under this Section. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Agreement.

3.9.4 If TENNCARE has not identified CONTRACTOR deficiencies, TENNCARE will pay to the CONTRACTOR the withhold of the CONTRACTOR's payments withheld in the month subsequent to the withhold.

3.10 EFFECT OF DISENROLLMENT ON CAPITATION PAYMENTS

Payment of capitation payments shall cease effective the date of the member's disenrollment from the CONTRACTOR's MCO, and the CONTRACTOR shall have no further responsibility for the care of the enrollee. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively.

3.10.1 Fraudulent Enrollment

3.10.1.1 In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TENNCARE all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the CONTRACTOR's MCO.

3.10.1.2 In the event of enrollment obtained by fraud, misrepresentation or deception by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the CONTRACTOR for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

3.11 HMO PAYMENT TAX

The CONTRACTOR shall be responsible for payment of applicable taxes pursuant to TCA 56-32-224. In the event the amount due pursuant to TCA 56-32-224 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

3.12 PAYMENT TERMS AND CONDITIONS

3.12.1 Maximum Liability

3.12.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed Eight Hundred Seventy Four Million, Three Hundred Fifty Four Thousand, Four Hundred Sixty Two Dollars ($874,354,462).

3.12.1.2 If the Agreement maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment pursuant to Section 3.4 above; or if there is a reduction in the total available funds for the payment of services under this Agreement, the State and the CONTRACTOR shall negotiate in good faith to reduce Agreement expenditures to the Agreement maximum level, or the State shall adjust the Agreement maximum liability to accommodate the aforementioned circumstances in consultation with the State's independent actuary.

3.12.1.3 This Agreement does not obligate the State to pay a fixed minimum amount and does not create in the CONTRACTOR any rights, interests or claims of entitlement in any funds.

3.12.1.4 The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Agreement or any extensions of the Agreement. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of these funds to the CONTRACTOR under this Agreement.

3.12.2 Compensation Firm

The capitation rates and the Maximum Liability of the State under this Agreement are firm for the duration of the Agreement and are not subject to escalation for any reason unless amended.

3.12.3 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, 2008 for all rate categories will be established through a competitive bid process, and the

capitation rate for the 'State Only and Judicials' rate category and the priority add-on rate will be established by the State. The base capitation rates, priority add-on rate, and the 'State Only and Judicials' rate for subsequent years will be established through the amendment process (see Section 4.21) in accordance with Section 3.

3.12.4 **Payment Methodology**

The CONTRACTOR shall be compensated in accordance with Section 3 above as authorized by the State in a total amount not to exceed the Agreement Maximum Liability established in Section 3.12.1 above. The CONTRACTOR's compensation shall be contingent upon the satisfactory completion of requirements under this Agreement.

3.12.5 **Return of Funds and Deductions**

3.12.5.1 The CONTRACTOR shall refund to TENNCARE any overpayments due or funds disallowed pursuant to this Agreement within thirty (30) calendar days of the date of written notification from TENNCARE, unless otherwise authorized by TENNCARE in writing.

3.12.5.2 The State reserves the right to deduct from amounts which are or shall become due and payable to the CONTRACTOR under this or any Agreement or contract between the CONTRACTOR and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the CONTRACTOR.

3.12.6 **Automatic Deposits**

The CONTRACTOR shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits)" form. This form shall be provided to the CONTRACTOR by the State. Once this form has been completed and submitted to the State by the CONTRACTOR all payments to the CONTRACTOR, under this or any other Agreement/contract the CONTRACTOR has with the State of Tennessee shall be made by Automated Clearing House (ACH). The CONTRACTOR shall not be paid under this Agreement until the CONTRACTOR has completed this form and submitted it to the State.

SECTION 4 - TERMS AND CONDITIONS

4.1 NOTICE

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States certified mail, postage prepaid, return receipt requested; in person; or by other means, so long as proof of delivery and receipt is given, and the cost of delivery is borne by the notifying party, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
310 Great Circle Rd
Nashville, Tennessee 37243

If to the CONTRACTOR:

Eric H. Paul
Cheif Executive Officer, TennCare Product
UnitedHealthcare Plan of the River Valley, Inc.
10 Cadillac Dr.
Suite 200
Brentwood, TN 37027

4.2 AGREEMENT TERM

4.2.1 Term of the Agreement

This Agreement, including any amendments, shall be effective commencing on August 15, 2006 and ending on June 30, 2010.

4.2.2 Term Extension

The State reserves the right to extend this Agreement for an additional period or periods of time representing increments of no more than one (1) year and a total term of no more than five (5) years, provided that the State notifies the CONTRACTOR in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. An extension of the term of this Agreement will be effected through an amendment to the Agreement.

4.2.3 Exigency Extension

4.2.3.1 At the option of the State, the CONTRACTOR agrees to continue services under this Agreement when TENNCARE determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days written notice shall be given by TENNCARE before this option is exercised.

4.2.3.2 A written notice of exigency extension shall constitute an amendment to the Agreement, may include a revision of the maximum liability and other adjustments permitted under Section 3, and shall be approved by the F&A Commissioner and the Comptroller of the Treasury.

4.2.3.3 During any periods of public exigency, TENNCARE shall continue to make payments to the CONTRACTOR as specified in Section 3 of this Agreement.

4.3 APPLICABLE LAWS AND REGULATIONS

The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, policies (including TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the CONTRACTOR pursuant to this Agreement)), consent decrees, and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

4.3.1 42 CFR Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4.3.2 45 CFR Part 74, General Grants Administration Requirements.

4.3.3 Titles 4, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the TennCare Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.

4.3.4 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 USC 7401, *et seq*.).

4.3.5 Title VI of the Civil Rights Act of 1964 (42 USC 2000d) and regulations issued pursuant thereto, 45 CFR Part 80.

4.3.6 Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment.

4.3.7 Section 504 of the Rehabilitation Act of 1973, 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84.

4.3.8 The Age Discrimination Act of 1975, 42 USC 6101 *et seq*., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

4.3.9 The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

4.3.10 Americans with Disabilities Act, 42 USC 12101 *et seq*., and regulations issued pursuant thereto, 28 CFR Parts 35, 36.

4.3.11 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare, SCHIP and/or Medicaid program.

4.3.12 Tennessee Consumer Protection Act, TCA 47-18-101 *et seq*.

4.3.13 The TennCare Section 1115 waiver and all Special Terms and Conditions which relate to the waiver.

4.3.14 Executive Orders, including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003.

4.3.15 The Clinical Laboratory Improvement Amendments (CLIA) of 1988.

4.3.16 Requests for approval of material modification as provided at TCA 56-32-201 *et seq*.

4.3.17 Investigatory Powers of TDCI pursuant to TCA 56-32-232.

4.3.18 42 USC 1396 *et seq*. (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4.3.19 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.

4.3.20 Title IX of the Education Amendments of 1972 regarding education programs and activities.

4.3.21 Title 42 CFR 422.208 and 210, Physician Incentive Plans.

4.3.22 Equal Employment Opportunity (EEO) Provisions.

4.3.23 Copeland Anti-Kickback Act.

4.3.24 Davis-Bacon Act.

4.3.25 Contract Work Hours and Safety Standards.

4.3.26 Rights to Inventions Made Under a Contract or Agreement.

4.3.27 Byrd Anti-Lobbying Amendment.

4.3.28 Subcontracts in excess of one-hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

4.3.29 Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P. L. 94-165.)

4.3.30 TennCare Reform Legislation signed May 11, 2004.

4.3.31 Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

4.3.32 Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

4.3.33 Title 33 (Mental Health Law) of the Tennessee Code Annotated.

4.3.34 Rules of the Tennessee Department of Mental Health and Developmental Disabilities, Rule 0940 *et seq*.

4.3.35 TennCare rules and regulations.

4.4 TERMINATION

In the event of termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Agreement. For terminations pursuant to Sections 4.4.1, 4.4.2, 4.4.3, or 4.4.5, TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the CONTRACTOR's MCO.

4.4.1 Termination Under Mutual Agreement

Under mutual agreement, TENNCARE and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of TENNCARE and the CONTRACTOR. Both parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Agreement is terminated.

4.4.2 Termination by TENNCARE for Cause

4.4.2.1 The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

4.4.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

4.4.2.1.2 The CONTRACTOR only renders partial performance of any term or provision of the Agreement; or

4.4.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

4.4.2.2 For purposes of Section 4.4.2, items 4.4.2.1.1 through 4.4.2.1.3 shall hereinafter be referred to as "Breach."

4.4.2.3 In the event of a Breach by the CONTRACTOR, TENNCARE shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this Agreement or available in law or equity:

4.4.2.3.1 Recover actual damages, including incidental and consequential damages, and any other remedy available at law or equity;

4.4.2.3.2 Require that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;

4.4.2.3.3 Recover any and/or all liquidated damages provided in Section 4.20.2; and

4.4.2.3.4 Declare a default and terminate this Agreement.

4.4.2.4 In the event of a conflict between any other Agreement provisions and Section 4.4.2.3, Section 4.4.2.3 shall control.

4.4.2.5 In the event of Breach by the CONTRACTOR, TENNCARE may provide the CONTRACTOR written notice of the Breach and twenty (20) calendar days to cure the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then TENNCARE shall have available any and all remedies described herein and available at law.

4.4.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

4.4.3 **Termination for Unavailability of Funds**

In the event that federal and/or state funds to finance this Agreement become unavailable, TENNCARE may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by TENNCARE.

4.4.4 **Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy**

4.4.4.1 If TENNCARE reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services as described herein in the manner required by TENNCARE, TENNCARE may terminate this Agreement in whole or in part, immediately or in stages. Said termination shall not be deemed a Breach by either party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described herein in the manner required by TENNCARE if the CONTRACTOR can not demonstrate to TENNCARE's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section 2.21.5 of this Agreement.

4.4.4.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor or provider or the insolvency of said subcontractor or provider, the CONTRACTOR shall immediately advise TENNCARE.

4.4.5 **Termination by TENNCARE for Convenience**

TENNCARE may terminate this Agreement for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a Breach of the Agreement by TENNCARE, and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

4.4.6 **Termination by CONTRACTOR**

4.4.6.1 Beginning in calendar year 2008, the CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination on or by July 1 of each calendar year after receipt of notice of the capitation payment rates to become effective in July. Said notice shall terminate the Agreement on the following December 31st.

4.4.6.2 The CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination when risk adjustment factors are updated in accordance with Section 3.4.3.5 due to a significant change in program participation. In this instance, the CONTRACTOR shall provide TENNCARE with written notice of termination within fourteen (14) calendar days of notice of the updated risk adjustment factors and capitation payment rates. Said notice shall terminate the Agreement six (6) months after the date of notice of risk adjustment factors and capitation payment rates plus fourteen (14) calendar days.

4.4.7 **Termination Procedures**

4.4.7.1 The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

4.4.7.2 Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

4.4.7.2.1 Stop work under the Agreement, but not before the termination date;

4.4.7.2.2 At the point of termination, assign to TENNCARE in the manner and extent directed by TENNCARE all the rights, title and interest of the CONTRACTOR for the performance of the subcontracts to be determined at need in which case TENNCARE shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;

4.4.7.2.3 Complete the performance of such part of the Agreement that shall have not been terminated under the notice of termination;

4.4.7.2.4 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement which is in possession of the CONTRACTOR and in which TENNCARE has or may acquire an interest;

4.4.7.2.5 In the event the Agreement is terminated by TENNCARE, continue to serve or arrange for provision of services to the enrollees in the CONTRACTOR's MCO for up to forty-five (45) calendar days from the Agreement termination date or until the members can be transferred to another MCO, whichever is longer. During this transition period, TENNCARE shall continue to make payment as specified in Section 3;

4.4.7.2.6 Promptly make available to TENNCARE, or another MCO acting on behalf of TENNCARE, any and all records, whether medical, behavioral or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided at no expense to TENNCARE;

4.4.7.2.7 Promptly supply all information necessary to TENNCARE or another MCO acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;

4.4.7.2.8 Submit a termination plan to TENNCARE for review, which is subject to TENNCARE approval. This plan must, at a minimum, contain the provisions in Sections 4.4.7.2.9 through 4.4.7.2.14 below. The CONTRACTOR shall agree to make revisions to the plan as necessary in order to obtain approval by TENNCARE. Failure to submit a termination plan and obtain approval of the termination plan by TENNCARE shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly capitation payment;

4.4.7.2.9 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims;

4.4.7.2.10 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the appeal process as described in Section 2.19;

4.4.7.2.11 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

4.4.7.2.12 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Agreement to coverage under any new arrangement developed by TENNCARE;

4.4.7.2.13 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Agreement until the State provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled; and

4.4.7.2.14 Upon expiration or termination of this Agreement, submit reports to TENNCARE every thirty (30) calendar days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to TENNCARE describing how the CONTRACTOR has completed its continuing obligations. TENNCARE shall within twenty (20) calendar days of receipt of this report advise in writing whether TENNCARE agrees that the CONTRACTOR has fulfilled its continuing obligations. If TENNCARE finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then TENNCARE shall require the CONTRACTOR to submit a revised final report. TENNCARE shall in writing notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of TENNCARE that the CONTRACTOR has fulfilled its continuing obligations.

4.5 ENTIRE AGREEMENT

4.5.1 This Agreement, including any amendments or attachments, represents the entire Agreement between the CONTRACTOR and TENNCARE with respect to the subject matter stated herein, and supersedes all other contracts between the parties with regard to the provision of services described herein. Any communications made before the parties entered into this Agreement, whether verbal or in writing, shall not be considered as part of or explanatory of any part of this Agreement.

4.5.2 In the event of a conflict of language between the Agreement and any amendments, the provisions of the amendments shall govern.

4.5.3 All applicable state and federal laws, rules and regulations, consent decrees, court orders and policies and procedures (hereinafter referred to as Applicable Requirements), including those described in Section 4.3 of this Agreement are incorporated by reference into this Agreement. Any changes in those Applicable Requirements shall be automatically incorporated into this Agreement by reference as soon as they become effective. However, as provided in Section 3.4.5 of this Agreement, changes that are likely to impact the actuarial soundness of the capitation rate(s) shall be reviewed by TENNCARE's actuary and the appropriate adjustment to the impacted capitation rate(s) will be made via amendment pursuant to Section 4.21.

4.5.4 Nothing contained herein shall prejudice, restrict or otherwise limit the CONTRACTOR's right to initiate action challenging such Applicable Requirements in a court of competent jurisdiction, including seeking to stay or enjoin the applicability or incorporation of such requirements into this Agreement.

4.6 INCORPORATION OF ADDITIONAL DOCUMENTS

4.6.1 Included in this Agreement by reference are the following documents:

4.6.1.1 The Agreement document and its attachments, as defined in Section 4.5 above;

4.6.1.2 All clarifications and addenda made to the CONTRACTOR's Proposal;

4.6.1.3 The Request for Proposal and its associated amendments;

4.6.1.4 Technical Specifications provided to the CONTRACTOR; and

4.6.1.5 The CONTRACTOR's Proposal.

4.6.2 In the event of a discrepancy or ambiguity regarding the CONTRACTOR's duties, responsibilities, and performance under this Agreement, these documents shall govern in order of precedence detailed above.

4.7 APPLICABILITY OF THIS AGREEMENT

4.7.1 All terms, conditions, and policies stated in this Agreement apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the CONTRACTOR.

4.7.2 TennCare enrollees are the intended third party beneficiaries of contracts between the State and the CONTRACTOR and of any subcontracts or provider agreements entered into by the CONTRACTOR with subcontracting providers, and, as such, enrollees are entitled to the remedies accorded to third party beneficiaries under the law. This provision is not intended to provide a cause of action against TENNCARE or the State of Tennessee by enrollees beyond any that may exist under state or federal law.

4.8 TECHNICAL ASSISTANCE

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE.

4.9 PROGRAM INFORMATION

Upon request, TENNCARE shall provide the CONTRACTOR complete and current information with respect to pertinent statutes, regulations, rules, policies, procedures, and guidelines affecting the CONTRACTOR's operation pursuant to this Agreement.

4.10 QUESTIONS ON POLICY DETERMINATIONS

On an ongoing basis, should the CONTRACTOR have a question on policy determinations, benefits or operating guidelines, the CONTRACTOR shall request a determination from TENNCARE in writing. The State shall have thirty (30) calendar days to make a determination and respond unless specified otherwise. Should TENNCARE not respond in the required amount of time, the CONTRACTOR shall not be penalized as a result of implementing items awaiting approval. However, failure to respond timely shall not preclude the State from requiring the CONTRACTOR to respond or modify the policy or operating guideline prospectively. The CONTRACTOR shall be afforded at least sixty (60) calendar days to implement the modification.

4.11 INTERPRETATIONS

Any dispute between the CONTRACTOR and TENNCARE concerning the clarification, interpretation and application of all federal and state laws, regulations, or policy or consent decrees or court orders governing or in any way affecting this Agreement shall be determined by TENNCARE. When a clarification, interpretation and application is required, the CONTRACTOR shall submit a written request to TENNCARE. TENNCARE will contact the appropriate agencies in responding to the request by submitting the written request to the agency within thirty (30) calendar days after receiving that request from the CONTRACTOR. Any

clarifications received pursuant to requests for clarification, interpretation and application shall be forwarded upon receipt to the CONTRACTOR. Nothing in this Section shall be construed as a waiver by the CONTRACTOR of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, or policy or consent decrees or court orders.

4.12 CONTRACTOR APPEAL RIGHTS

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 *et seq*. for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action must be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Agreement pending the final resolution of the contested action.

4.13 DISPUTES

Any claim by the CONTRACTOR against TENNCARE arising out of the breach of this Agreement shall be handled in accordance with the provision of TCA 9-8-301, *et seq*. Provided, however, the CONTRACTOR agrees that the CONTRACTOR shall give notice to TENNCARE of its claim thirty (30) calendar days prior to filing the claim in accordance with TCA 9-8-301, *et seq*.

4.14 NOTIFICATION OF LEGAL ACTION AGAINST THE CONTRACTOR

The CONTRACTOR shall give TENNCARE and TDCI immediate notification in writing by certified mail of any administrative or legal action filed regarding any claim made against the CONTRACTOR by a provider or enrollee which is related to the CONTRACTOR's responsibilities under this Agreement, including but not limited to notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Agreement.

4.15 DATA THAT MUST BE CERTIFIED

4.15.1 In accordance with 42 CFR 438.606 and 438.606, when State payments to the CONTRACTOR are based on data submitted by the CONTRACTOR, the CONTRACTOR shall certify the data. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents including the medical loss ratio (MLR) report. The data must be certified by one of the following: the CONTRACTOR's Chief Executive Officer, the CONTRACTOR's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the CONTRACTOR's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:

4.15.1.1 To the accuracy, completeness and truthfulness of the data; and

4.15.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.

4.15.2 The CONTRACTOR shall submit the certification concurrently with the certified data.

4.16 USE OF DATA

TENNCARE shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the CONTRACTOR resulting from this Agreement. However, TENNCARE shall not disclose proprietary information that is afforded confidential status by state or federal law.

4.17 WAIVER

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement may be waived except by written agreement of the Agreement signatories or in the event the signatory for a party is no longer empowered to sign such Agreement, the signatory's replacement. Forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

4.18 AGREEMENT VARIATION/SEVERABILITY

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both TENNCARE and the CONTRACTOR shall be relieved of all obligations arising under such provision. If the remainder of the Agreement is capable of performance, it shall not be affected by such declaration of finding and shall be fully performed. In addition, if the laws or regulations governing this Agreement should be amended or judicially interpreted as to render the fulfillment of the Agreement impossible or economically unfeasible, both TENNCARE and the CONTRACTOR will be discharged from further obligations created under the terms of the Agreement.

4.19 CONFLICT OF INTEREST

4.19.1 The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of Section 4.19 and its subparts of this contract, "immediate family member" shall mean a spouse or minor child(ren) living in the household.

4.19.1.1 Quarterly, by January 30, April 30, July 30, and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Bureau of TennCare, disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include, but not be limited to, the following:

4.19.1.1.1 A list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the CONTRACTOR; and

4.19.1.1.2 A statement of the reason or purpose for the wages or compensation.

The disclosures shall be made by the CONTRACTOR and reviewed by TENNCARE in accordance with Standard Operating Procedures and the disclosures shall be distributed to, amongst other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee.

4.19.1.2 This Agreement may be terminated by TENNCARE and/or the CONTRACTOR may be subject to sanctions, including liquidated damages, under this Agreement if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law. It is understood by and between the parties that the failure to disclose information as required under Section 4.19 of this Agreement may result in termination of this Agreement and the CONTRACTOR may be subject to sanctions, including liquidated damages in accordance with Section 4.20 of this Agreement. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

4.19.2 The CONTRACTOR shall include language in all subcontracts and provider agreements and any and all agreements that result from this Agreement between CONTRACTOR and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. Said language may make applicable the provisions of Section 4.19 to all subcontracts, provider agreements and all agreements that result from the Agreement between the CONTRACTOR and TENNCARE.

4.20 FAILURE TO MEET AGREEMENT REQUIREMENTS

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of CONTRACTOR's failure to meet the requirements provided in this Agreement and all documents incorporated herein, TENNCARE will be harmed. The actual damages which TENNCARE will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the CONTRACTOR shall be subject to damages and/or sanctions as described below. It is further agreed that the CONTRACTOR shall pay TENNCARE liquidated damages as directed by TENNCARE; provided however, that if it is finally determined that the CONTRACTOR would have been able to meet the Agreement requirements listed below but for TENNCARE's failure to perform as provided in this Agreement, the CONTRACTOR shall not be liable for damages resulting directly therefrom.

4.20.1 **Intermediate Sanctions**

4.20.1.1 TENNCARE may impose any or all of the sanctions as described in this Section upon TENNCARE's reasonable determination that the CONTRACTOR failed to comply with any corrective action plan (CAP) as described under Section 2.25.9 or Section 2.23.13 of this Agreement, or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:

4.20.1.1.1 Fails substantially to provide medically necessary covered services;

4.20.1.1.2 Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TENNCARE;

4.20.1.1.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services;

4.20.1.1.4 Misrepresents or falsifies information that it furnishes to CMS or to the State;

4.20.1.1.5 Misrepresents or falsifies information that it furnishes to a member, potential member, or provider;

4.20.1.1.6 Fails to comply with the requirements for physician incentive plans, as required by 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR 422.208 and 422.210;

4.20.1.1.7 Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and

4.20.1.1.8 Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

4.20.1.2 TENNCARE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include:

4.20.1.2.1 Liquidated damages as described in Section 4.20.2;

4.20.1.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

4.20.1.2.3 Disenrollment of members;

4.20.1.2.4 Limitation of the CONTRACTOR's service area;

4.20.1.2.5 Civil monetary penalties as described in 42 CFR 438.704;

4.20.1.2.6 Appointment of temporary management for an MCO as provided in 42 CFR 438.706;

4.20.1.2.7 Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;

4.20.1.2.8 Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or

4.20.1.2.9 Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance.

4.20.2 **Liquidated Damages**

4.20.2.1 Reports and Deliverables

4.20.2.1.1 For each day that a report or deliverable is late, incorrect, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one-hundred dollars ($100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.

4.20.2.1.2 Liquidated damages for incorrect reports or deficient deliverables shall begin on the first day after the report/deliverable was due.

4.20.2.1.3 For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due as specified elsewhere in this Agreement or by TENNCARE.

4.20.2.2 Program Issues

4.20.2.2.1 Liquidated damages for failure to perform specific responsibilities or responsibilities as described in this Agreement are shown in the chart below. Damages are grouped into three categories: **Level A**, **Level B**, and **Level C** program issues.

4.20.2.2.2 Failure to perform specific responsibilities or requirements categorized as **Level A** are those which pose a significant threat to patient care or to the continued viability of the TENNCARE program.

4.20.2.2.3 Failure to perform specific responsibilities or requirements categorized as **Level B** are those with pose threats to the integrity of the TENNCARE program, but which do not necessarily imperil patient care.

4.20.2.2.4 Failure to perform specific responsibilities or requirements categorized as **Level C** are those which represent threats to the smooth and efficient operation of the TENNCARE program but which do not imperil patient care or the integrity of the TENNCARE program.

4.20.2.2.5 TENNCARE may also assess liquidated damages for failure to meet performance standards as provided in Section 2.24.3 and Attachment VII of this Agreement.

4.20.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five-hundred dollars ($500) per occurrence with any notice of deficiency.

4.20.2.2.7 *Liquidated Damages Chart*

LEVEL	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in Section 2.22 of this Agreement		$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2.22 of this Agreement
A.2	Failure to comply with licensure requirements in Section 2.29.2 of this Agreement		$5,000 per calendar day that staff/provider/agent/subcontractor is not licensed as required by applicable state law plus the amount paid to the staff/provider/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater
A.4	Failure to comply with obligations and time frames in the delivery of TENNderCare screens and related services		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater

LEVEL	PROGRAM ISSUES		DAMAGE
A.6(a)	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE (pursuant to an appeal) to do so, or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$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.6(b)	Failure to provide proof of compliance to TENNCARE within five (5) calendar days of a reasonable and appropriate directive from TENNCARE or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$500 per day beginning on the next calendar day after default by the CONTRACTOR
A.7	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2.7.7 of this Agreement		$500 per occurrence or the actual amount of the federal penalty created by the CONTRACTOR's failure to comply, whichever is greater
A.8	Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 2.7.4.2 of this Agreement		$500 per day, per occurrence, for each calendar day that care is not provided in accordance with the terms of this Agreement
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 beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE

LEVEL	PROGRAM ISSUES		DAMAGE
A.10	Failure to comply with the notice requirements of this Agreement, TennCare rules and regulations or any subsequent amendments thereto, and all court orders and consent decrees governing appeal procedures, as they become effective		$500 per occurrence in addition to $500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.11	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days		$500 per calendar day
A.12	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective		$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.13	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member		$1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1,000 for the second day, $1,500 for the third day, etc.) for each day the notice is late and/or remains defective

LEVEL	PROGRAM ISSUES		DAMAGE
A.14	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective		First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TENNCARE) Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" ($500 per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; $1,000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)
A. 15	Failure to 1) provide an approved service timely, i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver (see Attachment III), or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service		The cost of services not provided plus $500 per day, per occurrence, for each day 1) that approved care is not provided timely; or 2) notice of delay is not provided and/or the CONTRACTOR fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
B.1	Failure to provide referral provider listings to PCPs as required by Section 2.14.3.5 of this Agreement		$500 per calendar day
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE		$500 per calendar day for each day the corrective action is not completed or complied with as required
B.3	Failure to submit Audited HEDIS and CAHPS results annually by June 15 as described in Sections 2.15.6 and 2.15.7		$250 per day for every calendar day reports are late
B.4	Failure to submit NCQA Accreditation Report as described in Sections 2.15.6		$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported

LEVEL	PROGRAM ISSUES		DAMAGE
B.5	Failure to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements described in Section 4.19, 4.23, or 4.24		110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals
B.6	Failure to disclose lobbying activities as required by Section 4.24 and 2.30.21		$1000 per day that disclosure is late
B.7	Failure to comply with Offer of Gratuities constraints described in Section 4.23		110% of the total benefit provided by the CONTRACTOR to inappropriate individuals
B.8	Failure to obtain approval of member materials as required by Section 2.17 of this Agreement		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided member material that has not been approved by TENNCARE
B.9	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, and Quarterly Member Newsletters as required in Section 2.17		$5000 for each occurrence
B.10	Failure to achieve and/or maintain financial requirements in accordance with TCA		$500 per calendar day for each day that financial requirements have not been met
B.11	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.30.14.3		$500 per calendar day
B.12	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.30.14.3		$500 per calendar day
B.13	Failure to submit audited financial statements as described in Section 2.30.14.3		$500 per calendar day
B.14	Failure to comply with fraud and abuse provisions as described in Section 2.20 of this Agreement		$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions
B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.7.50 of this Agreement		$5000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B

LEVEL	PROGRAM ISSUES		DAMAGE
B.16	Failure to maintain a complaint and appeal system as required in Section 2.19 of this Agreement		$500 per calendar day
B.17	Failure to maintain required insurance as required in Section 2.21.7 of this Agreement		$500 per calendar day
B.18	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.6.3.2 of this Agreement		$1,000 per occurrence per case
B.19	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement		$500 per occurrence
B.20	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.7.2.9 of this Agreement		$500 per month per Enrollee
B.21	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.7.2.9 of this Agreement		$500 per occurrence per case
B.22	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required in Section 2.11.7 of this Agreement		$5000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable And/Or $1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed as described in Section 2.11.7 of this Agreement

LEVEL	PROGRAM ISSUES		DAMAGE
B.23	Failure to maintain provider agreements in accordance with Section 2.12 of this Agreement		$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 2.12 of this Agreement
C.1	Failure to comply in any way with staffing requirements as described in Section 2.29.1 of this Agreement		$250 per calendar day for each day that staffing requirements are not met
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's MCO		$250 per day
C.3	Failure to comply in any way with encounter data submission requirements as described in Section 2.23 of this Agreement (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE)		$25,000 per occurrence
C.4	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE		An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE

4.20.2.3 Payment of Liquidated Damages

4.20.2.3.1 It is further agreed by TENNCARE and the CONTRACTOR that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days after CONTRACTOR receipt of the notice of damages. If payment is not made by the due date, said liquidated damages may be withheld from future payments by TENNCARE without further notice, as provided in Section 3.12.5 of this Agreement. It is agreed by TENNCARE and the CONTRACTOR that the collection of liquidated damages by TENNCARE shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by TENNCARE will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the liquidated damages described in this Section. With respect to **Level B** and **Level C** program issues (failure to perform responsibilities or requirements), the due dates mentioned above may be delayed if the CONTRACTOR can show good cause as to why a delay should be granted. TENNCARE has sole discretion in determining whether good cause exists for delaying the due dates.

4.20.2.3.2 Liquidated damages as described in Section 4.20.2 shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the

provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

4.20.2.3.3 All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the CONTRACTOR out of administrative costs and profits.

4.20.2.4 Waiver of Liquidated Damages

TENNCARE may waive the application of liquidated damages and/or withholds upon the CONTRACTOR if the CONTRACTOR is placed in rehabilitation or under administrative supervision if TENNCARE determines that such waiver is in the best interests of the TennCare program and its enrollees.

4.20.3 **Claims Processing Failure**

If it is determined that there is a claims processing deficiency related to the CONTRACTOR's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section 2.22, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of liquidated damages and/or intermediate sanctions specified in Sections 4.20.1 and 4.20.2 and the retention of withholds as specified in Section 3.9. If the CONTRACTOR is unable to successfully implement corrective action and demonstrate adherence with timely claims processing requirements within the time approved by TENNCARE, the State may terminate this Agreement in accordance with Section 4.4 of this Agreement.

4.20.4 **Failure to Manage Medical Costs**

If TENNCARE determines the CONTRACTOR is unable to successfully manage costs for covered services, TENNCARE may terminate this Agreement with ninety (90) calendar days advance notice in accordance with Section 4.4 of this Agreement.

4.20.5 **Sanctions by CMS**

Payments provided for under this Agreement will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

4.20.6 **Temporary Management**

TENNCARE may impose temporary management if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

4.21 MODIFICATION AND AMENDMENT

This Agreement may be modified only by a written amendment executed by all parties hereto and approved by the appropriate State of Tennessee officials in accordance with applicable State of Tennessee laws and regulations. Such amendment shall be effective on the date agreed to by TENNCARE and the CONTRACTOR.

4.22 TITLES/HEADINGS

Titles of paragraphs or section headings used herein are for the purpose of facilitating use or reference only and shall not be construed to infer a contractual construction of language.

4.23 OFFER OF GRATUITIES

By signing this Agreement, the CONTRACTOR certifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining this Agreement. This Agreement may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR or the CONTRACTOR's agent or employees.

4.24 LOBBYING

4.24.1 The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 *et seq*., 3-6-201 *et seq*., 3-6-301 *et seq*., and 8-50-505.).

4.24.2 The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

4.25 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Agreement, and TENNCARE prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorney's fees and cost of all state litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

4.26 GOVERNING LAW AND VENUE

4.26.1 This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee. The CONTRACTOR agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Agreement.

4.26.2 For purposes of any legal action occurring as a result of or under this Agreement between the CONTRACTOR and TENNCARE, the place of proper venue shall be Davidson County, Tennessee.

4.27 ASSIGNMENT

This Agreement and the monies which may become due hereunder are not assignable by the CONTRACTOR except with the prior written approval of TENNCARE.

4.28 INDEPENDENT CONTRACTOR

It is expressly agreed that the CONTRACTOR and any subcontractors or providers, and agents, officers, and employees of the CONTRACTOR or any subcontractors or providers, in the

performance of this Agreement shall act in an independent capacity and not as agents, officers and employees of TENNCARE or the State of Tennessee. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between the CONTRACTOR or any subcontractor or provider and TENNCARE and the State of Tennessee.

4.29 FORCE MAJEURE

TENNCARE shall not be liable for any excess cost to the CONTRACTOR for TENNCARE's failure to perform the duties required by this Agreement if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of TENNCARE. In all cases, the failure to perform must be beyond the control without the fault or negligence of TENNCARE. The CONTRACTOR shall not be liable for performance of the duties and responsibilities of this Agreement when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the CONTRACTOR. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the CONTRACTOR shall be responsible for ensuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of covered services. The failure of the CONTRACTOR's fiscal intermediary to perform any requirements of this Agreement shall not be considered a 'force majeure'.

4.30 DATE/TIME HOLD HARMLESS

As required by TCA 12-4-118, the CONTRACTOR shall hold harmless and indemnify the State of Tennessee; its officers and employees; and any agency or political subdivision of the State for any Breach caused directly or indirectly by the failure of computer software or any device containing a computer processor to accurately or properly recognize, calculate, display, sort or otherwise process dates or times.

4.31 INDEMNIFICATION

4.31.1 The CONTRACTOR shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the CONTRACTOR to comply with the terms of this Agreement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

4.31.2 The CONTRACTOR shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the CONTRACTOR's or Indemnified Parties performance under this Agreement. In any such action, brought against the Indemnified Parties, the CONTRACTOR shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct the CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

4.31.3 While the State will not provide a contractual indemnification to the CONTRACTOR, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to the CONTRACTOR. The CONTRACTOR retains all of its rights to seek legal remedies against the State for losses the CONTRACTOR may incur in connection with the furnishing of services under this Agreement or for the failure of the State to meet its obligations under the Agreement.

4.32 NON-DISCRIMINATION

4.32.1 No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section 2.3.5 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the CONTRACTOR.

4.32.2 The CONTRACTOR shall upon request show proof of such non-discrimination.

4.32.3 The CONTRACTOR shall post notices of non-discrimination in conspicuous places, available to all employees and applicants.

4.33 CONFIDENTIALITY OF INFORMATION

4.33.1 The CONTRACTOR shall comply with all state and federal law regarding information security and confidentiality of information. In the event of a conflict among these requirements, the CONTRACTOR shall comply with the most restrictive requirement.

4.33.2 All material and information, regardless of form, medium or method of communication, provided to the CONTRACTOR by the State or acquired by the CONTRACTOR pursuant to this Agreement shall be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the CONTRACTOR to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

4.33.3 The CONTRACTOR shall ensure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CONTRACTOR's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be treated as confidential information to the extent confidential treatment is provided under state and federal laws. The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement and in compliance with federal and state law.

4.33.4 All information as to personal facts and circumstances concerning members or potential members obtained by the CONTRACTOR shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TENNCARE or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Agreement and shall be in compliance with federal and state law.

4.34 TENNESSEE CONSOLIDATED RETIREMENT SYSTEM

The CONTRACTOR acknowledges and understands that, subject to statutory exceptions contained in TCA 8-36-801, *et seq*., the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to TCA, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Agreement to the contrary, the CONTRACTOR agrees that if it is later determined that the true nature of the working relationship between the CONTRACTOR and the State under this Agreement is that of "employee/employer" and not that of an independent contractor, the CONTRACTOR may be required to repay to TCRS the amount of retirement benefits the CONTRACTOR received from TCRS during the period of this Agreement.

4.35 ACTIONS TAKEN BY THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

The parties acknowledge that the CONTRACTOR is licensed to operate as a health maintenance organization in the State of Tennessee, and is subject to regulation and supervision by TDCI. The parties acknowledge that no action by TDCI to regulate the activities of the CONTRACTOR as a health maintenance organization, including, but not limited to, examination, entry of a remedial order pursuant to TCA 56-9-101, *et seq*., and regulations promulgated thereunder, supervision, or institution of delinquency proceedings under state law, shall constitute a breach of this Agreement by TENNCARE.

4.36 EFFECT OF THE FEDERAL WAIVER ON THIS AGREEMENT

The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement. Said termination shall not be a breach of this Agreement by TENNCARE and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination.

4.37 TENNCARE FINANCIAL RESPONSIBILITY

Notwithstanding any provision which may be contained herein to the contrary, TENNCARE shall be responsible solely to the CONTRACTOR for the amount described herein and in no event shall TENNCARE be responsible, either directly or indirectly, to any subcontractor or any other party who may provide the services described herein.

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 /scs
M.D. Goetz, Jr.
Commissioner

DATE: 8-16-06

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

BY: Eric H. Paul
Eric H. Paul
Chief Executive Officer, TennCare

DATE: 8/11/06

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M.D. Goetz Jr /JS
M.D. Goetz, Jr.
Commissioner

DATE: AUG 2 9 2006

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 9/5/06

ATTACHMENTS

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

SERVICE	**Mental Health Case Management**

DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team	One (1) contact per week

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
	15 individuals:1 case manager	
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

1) All mental health case managers shall have, at a minimum, a bachelor's degree;
2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages;
4) Eighty percent (80%) of all mental health case management services should take place outside the case manager's office;
5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the ACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) No arbitrary time limit on receiving services;
8) Individualized treatment, support and rehabilitation services;

9) Twenty-four (24) hour a day availability of services; and
10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the "imminent" risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members. These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

Supported Housing

Supported housing services refers to facilities 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 facilities are for persons with serious and/or persistent mental illnesses (SPMI) and are not residential treatment facilities. Supported housing is intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings with appropriate mental health supports. Given this goal, every effort should be made to place individuals near their families and other support systems and original areas of residence. Supported housing does not include the payment of room and board.

ATTACHMENT II
COST SHARING SCHEDULE

ATTACHMENT II
COST SHARING SCHEDULE

Non-Pharmacy Copayment Schedule
(unless otherwise directed by TENNCARE)

Poverty Level	Copayment Amounts
0% - 99%	$0.00
100% - 199%	$25.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists (including Psychiatrists) $200.00, Inpatient Hospital Admission

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this attachment.

ATTACHMENT III
TERMS AND CONDITIONS FOR ACCESS

ATTACHMENT III
TERMS AND CONDITIONS FOR ACCESS

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. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 4.

    + Tracking - Plans must have a system in place to document the exchange of client 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.

- General Dental Services:

  (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community 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.

- 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.

- Pharmacy 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.

- 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.

Definition of "Usual and Customary" - access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

- State will monitor, on a periodic or continuous basis (but no less often than every 12 months), Plans adherence to these standards, through the following mechanisms: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following State activities: periodic comparison of the number and types of providers before and after the waiver, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.

- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

(1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

(2) The following access standards are met:

- Travel distance does not exceed 60 miles for at least 75% of non-dual members and
- Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000

Specialty	Number of Non-Dual Members
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

Service Type	Geographic Access Requirement for the Service	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	In accordance with Attachment III for Hospitals	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Within 100 miles of an individual's residence	Within 30 calendar days
Outpatient Mental Health Services:		
MD Services (Psychiatry)	In accordance with Attachment IV for Psychiatry	Within 14 calendar days; if urgent, within 3 business days
Outpatient Non-MD Services	Within 30 miles of an individual's residence	Within 14 calendar days; if urgent, within 3 business days
Intensive Outpatient/ Partial Hospitalization	Within 60 miles of an individual's residence	Within 14 calendar days; if urgent, within 3 business days
Inpatient, Residential & Outpatient Substance Abuse Services:		
Inpatient Facility Services	Within 60 miles of an individual's residence	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
Residential Treatment Services	Within 100 miles of an individual's residence	Within 14 calendar days
Outpatient Treatment Services	Within 30 miles of an individual's residence	Within 14 calendar days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to access standards	Within 7 calendar days
Psychiatric Rehabilitation Services:		
Psychosocial Rehabilitation	Within 60 miles of an individual's residence	Within 14 calendar days
Supported Employment	Within 60 miles of an individual's residence	Within 14 calendar days
Peer Support	Not subject to access standards	Within 30 calendar days
Illness Management & Recovery	Within 60 miles of an individual's residence	Within 30 calendar days
Supported Housing	Not Applicable*	Within 30 calendar days
Behavioral Health Crisis Services		
Entry into Behavioral Health Crisis Services	Not subject to access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Respite	Not subject to access standards	Within 2 hours of referral
Crisis Stabilization	Not subject to access standards	Within 4 hours of referral

*Placement of an individual more than 60 miles from his/her residence must be prior approved by the member or his/her legally appointed representative.

ATTACHMENT VI
FORMS FOR REPORTING FRAUD AND ABUSE

TENNESSEE BUREAU OF INVESTIGATION
MEDICAID FRAUD CONTROL UNIT

FRAUD ALLEGATION REFERRAL FORM

DATE: _____

TO (circle recipient): **SAC Bob Schlafly [*fax (615) 744-4659]***
ASAC Stephen Phelps [*fax (731) 668-9769]*
ASAC Norman Tidwell [*fax (615) 744-4659]*

FROM: _____ **(TennCare Contractor)**

Contact Person: _____
Telephone: _____
E-Mail: _____

SUBJECT NAME: _____ **d/b/a**_____
SUBJECT ADDRESS: _____ _____
_____ _____
_____
_____

PROVIDER NUMBER(S): _____
_____
_____

SUMMARY OF COMPLAINT:_____
_____
_____
_____
_____
_____
_____
_____
_____

ADDITIONAL SUBJECT INFORMATION: _____
_____
_____
_____

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting recipient name or name of individual suspected of fraud

Other Names Used (If known) alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable) SSN, if known DOB, if known

SSN, if known DOB, if known

Spouse's Name (if applicable)

Street Address physical address

Apartment #

City, State, Zip city state zip

Other Addresses Used

Home Phone Number

area code

Work Phone Number (Please include)

area code

Employer's Name

Employer's Address

Employer's Phone #

area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care Contractor of this problem? ☐ Yes ☐ No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? ☐ No ☐ Yes name phone dept/ business

Requesting Drug Profile ☐ Yes ☐ No Have already received drug profile ☐ Yes ☐ No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228
FRAUD TOLL FREE HOTLINE 1-800-433-3982 •FAX (615) 256-3852
E-Mail Address: www.tennessee.gov/tenncare (follow the prompts that read "Report Fraud Now")

ATTACHMENT VII
PERFORMANCE STANDARDS

ATTACHMENT VII
PERFORMANCE STANDARDS

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
1	Timely Claims Processing	Report from TDCI	90% of claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of claims are processed within sixty (60) calendar days.	Percentage of claims paid within 30 calendar days of receipt of claim, determined for each month in the quarter Percentage of claims processed within 60 calendar days of receipt of claim, determined for each month in the quarter	Quarterly	$10,000 for each month determined not to be in compliance
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately; determined for each month in the quarter	Quarterly	$5,000 for each full percentage point accuracy is below 97% for each quarter
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness - Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
5	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month
6	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
7	Specialist Provider Network	Provider Enrollment File	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology 2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service 3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s) 4. Center of Excellence for Behavioral Health: Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Provider Listing Accuracy	EQRO report	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of records for participating providers on the most recent monthly provider listing used to contact the provider and confirm the provider is participating in the CONTRACTOR's network	Quarterly	$25,000 per quarter if less than 90% of listed providers confirm participation. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or waived if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers are participating
9	Distance from provider to member	Provider Enrollment File	In accordance with Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE
10	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment V
11	Percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment)	Claims and encounter data	The percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment) will not be less than 76%	The number of SPMI/SED members receiving a behavioral health service (excluding a CRG/TPG assessment) during the fiscal year divided by the MCO's number of SPMI/SED members during the fiscal year is not less than the benchmark	Annually	$25,000 for each year determined to not be in compliance

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
12	Non-IMD Inpatient Use	Behavioral Health Crisis Service Response Reports and utilization data	10% decrease of total inpatient days at freestanding psychiatric hospitals subject to IMD exclusion compared to the base year's utilization	Total inpatient psychiatric hospital days at IMD exclusion facilities for members reduced by 10% after base line year	Annually	$10,000 for each year determined to not be in compliance
13	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Quarterly	$5,000 for each full percentage point TENNderCare screening ratio is below 80% for the most recent rolling twelve month period
14	Increase in utilization of supported employment	Supported Employment Reports	15% of all adults (21 – 64 years of age) designated as SPMI actively receiving supported employment services will be gainfully employed in either part time or full time capacity for a continuous 90 day period	Total number of SPMI adults receiving supported employment services as defined in Attachment I employed for a continuous 90-day period divided by the total number of SPMI adults	Annually	$25,000 for each year determined to not be in compliance
15	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60%
16	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health case management service	Mental Health Case Management Report	90% of discharged members *receive* a mental health case management service as medically necessary within seven (7) calendar days of discharge, excluding situations involving member reschedules, no shows, and refusals	(1) Number of members discharged by length of time between discharge and first subsequent mental health case management service as medically necessary reported by CMHA and type of service received; determined for each month (2) Average length of time between hospital discharge and first subsequent medically necessary MHCM visit reported by CMHA and type of service received excluding member reschedules, no shows, and refusals; determined for each month	Quarterly	$3,000 for each quarter determined to not be in compliance

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
17	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly	$1,500 for each quarter determined to not be in compliance
18	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly	$1,500 for each quarter determined to not be in compliance
19	Members are satisfied with the services they receive from behavioral health providers	Annual consumer satisfaction survey administered by TDMHDD	85% of respondents rate their experience to be fair or better	Distribution of members by satisfaction score	Annually	$10,000 for each response below 85%

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the TennCare Bureau unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.3

6. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.5

7. Policies and procedures for advance directives that ensure compliance with Section 2.7.6

8. Disease management program policies and procedures that ensure compliance with Section 2.8

9. Service coordination policies and procedures that ensure compliance with Section 2.9.1

10. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

11. Transition of care polices and procedures that ensure compliance with Section 2.9.3

12. MCO case management policies and procedures that ensure compliance with Section 2.9.4

13. Policies and procedures for coordination of physical and behavioral health services that ensure compliance with Section 2.9.5

14. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.5.2 to ensure compliance with Section 2.9.5

15. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.6

16. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.7

17. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.8

18. Identification of members serving on the claims coordination committee in accordance with Section 2.9.8.5.3

19. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.9

20. Policies and procedures to increase the use of HCBS waivers in compliance with Section 2.9.10

21. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.11

22. Polices and procedures regarding non-covered services that ensure compliance with Section 2.10

23. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

24. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

25. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

26. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.7

27. Policies and procedures that ensure compliance with notice requirements in Section 2.11.8

28. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.8.2

29. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

30. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.7.39)

31. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.5)

32. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.5)

33. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.6.1

34. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.5

35. Information on PCP profiling as requested by TENNCARE (see Section 2.14.5)

36. QM/QI policies and procedures to ensure compliance with Section 2.15

37. Clinical practice guidelines to ensure compliance with Section 2.15.5

38. Copy of signed contract with NCQA approved vendor to perform 2009 CAHPS as required by Section 2.15.6

39. Copy of signed contract with NCQA approved vendor to perform 2009 HEDIS audit as required by Section 2.15.6

40. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.6.1)

41. HEDIS BAT as required by Section 2.15.6

42. Copy of signed NCQA survey as required by Section 2.15.6.1

43. Notice of date for ISS submission and NCQA onsite review as required by Section 2.15.6.1

44. Notice of final payment to NCQA as required by Section 2.15.6.1

45. Notice of submission of ISS to NCQA as required by Section 2.15.6.1

46. Copy of completed NCQA survey and final report as required by Section 2.15.6.1

47. Notice of any revision to NCQA accreditation status

48. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletter, identification card, and provider directory along with any required supporting materials

49. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

50. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

51. Provider services and utilization management phone line policies and procedures that ensure compliance with Section 2.18.4

52. Provider handbook that is in compliance with requirements in Section 2.18.5

53. Provider education and training plan and materials that ensure compliance with Section 2.18.6

54. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.1)

55. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

56. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.9

57. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

58. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

59. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

60. Fraud and abuse compliance plan (see Section 2.20.3)

61. TPL policies and procedures that ensure compliance with Section 2.21.4

62. Accounting policies and procedures that ensure compliance with Section 2.21.6

63. Proof of insurance coverage (see Section 2.21.7)

64. Claims management policies and procedures that ensure compliance with Section 2.22

65. Internal claims dispute procedure (see Section 2.22.5)

66. EOB policies and procedures to ensure compliance with Section 2.22.8

67. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

68. Proposed approach for remote access in accordance with Section 2.23.6.10

69. Information security plan as required by Section 2.23.6.11

70. Notification of Systems problems in accordance with Section 2.23.7

71. Systems Help Desk services in accordance with Section 2.23.8

72. Notification of changes to Systems in accordance with Section 2.23.9

73. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

74. Medical record keeping policies and procedures that ensure compliance with Section 2.24.4

75. Subcontracts (see Section 2.26)

76. HIPAA policies and procedures that ensure compliance with Section 2.27

77. Accounting of disclosures in accordance with Section 2.27.2.10

78. Notification of use or disclosure in accordance with Section 2.27.2.13.3.3

79. Notification of any unauthorized acquisition of enrollee PHI in accordance with Section 2.27.2.13.3

80. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27.2.27

81. Notification of any security incident in accordance with Section 2.27.3

82. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

83. Changes to key staff as required by Section 2.29.1.2

84. Staffing plan as required by Section 2.29.1.7

85. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.8

86. List of officers and members of Board of Directors (see Section 2.29.3)

87. Changes to officers and members of Board of Directors (see Section 2.29.3)

88. Eligibility and Enrollment Data (see Section 2.30.2.1)

89. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)

90. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)

91. Information on members (see Section 2.30.2.4)

92. Service Threshold Report (see Section 2.30.3)

93. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)

94. Mental Health Case Management Report (see Section 2.30.4.2)

95. Supported Employment Report (see Section 2.30.4.3)

96. Behavioral Health Crisis Response Report (see Section 2.30.4.4)

97. Member CRG/TPG Assessment Report (see Section 2.30.4.5)

98. Rejected CRG/TPG Assessment Report (see Section 2.30.4.6)

99. CRG/TPG Assessments Audit Report (see Section 2.30.4.7)

100. Methodology for conducting CRG/TPG assessment audits (see Section 2.30.4.8)

101. Health Education/Outreach Report (see Section 2.30.4.9)

102. TENNderCare Report (see Section 2.30.4.10)

103. Disease Management Update Report (see Section 2.30.5.1)

104. Disease Management Report (see Section 2.30.5.2)

105. MCO Case Management Update Report (see Section 2.30.6.1)

106. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.2)

107. Pharmacy Services Report (see Section 2.30.6.3)

108. Pharmacy Services Report, On Request (see Section 2.30.6.4)

109. Provider Enrollment File (see Section 2.30.7.1)

110. Provider Compliance with Access Requirements Report (see Section 2.30.7.2)

111. PCP Assignment Report (see Section 2.30.7.3)

112. Report of Essential Hospital Services (see Section 2.30.7.4)

113. Behavioral Health Initial Appointment Timeliness Report (see Section 2.30.7.5)

114. FQHC Reports (see Section 2.30.7.6)

115. Single Case Agreements Report (see Section 2.30.8)

116. Related Provider Payment Report (see Section 2.30.9)

117. UM P&P, annual evaluation, and work plan (see Section 2.30.10.1)

118. ED Utilization Report (see Section 2.30.10.2)

119. Cost and Utilization Reports (see Section 2.30.10.3)

120. Cost and Utilization Summaries (see Section 2.30.10.4)

121. Identification of high-cost claimants (see Section 2.30.10.5)

122. Prior Authorization Reports (see Section 2.30.10.6)

123. Referral Provider Listing and supporting materials (see Section 2.30.10.7)

124. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.11.1)

125. Quality Update Report (see Section 2.30.11.2)

126. Report on Performance Improvement Projects (see Section 2.30.11.3)

127. Reports of Performance Indicator Results, Audited CAHPS Results, and Audited HEDIS Results (see Section 2.30.11.4)

128. NCQA Accreditation Report (see Section 2.30.11.5)

129. Member Services and UM Phone Line Report (see Section 2.30.12.1)

130. Translation/Interpretation Services Report (see Section 2.30.12.3)

131. Provider Satisfaction Survey Report (see Section 2.30.12.4)

132. Provider Complaints Report (see Section 2.30.12.5)

133. Fraud and Abuse Activities Report (see Section 2.30.13)

134. Recovery and Cost Avoidance Report (see Section 2.30.14.1.1)

135. Other Insurance Report (see Section 2.30.14.1.2)

136. Medical Loss Ratio (MLR) Report (see Section 2.30.14.2.1)

137. Ownership and Financial Disclosure Report (see Section 2.30.14.2.2)

138. Annual audit plan (see Section 2.30.14.2.3)

139. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.14.3.1)

140. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.14.3.2)

141. Annual Financial Report (to TDCI) (see Section 2.30.14.3.3)

142. Quarterly Financial Report (to TDCI) (see Section 2.30.14.3.4)

143. Audited Financial Statements (to TDCI) (see Section 2.30.14.3.5)

144. Claims Payment Accuracy Report (see Section 2.30.15.1)

145. EOB Report (see Section 2.30.15.2)

146. Systems Refresh Plan (see Section 2.30.16.1)

147. Encounter Data Files (see Section 2.30.16.2)

148. Electronic version of claims paid reconciliation (see Section 2.30.16.3)

149. Information and/or data to support encounter data submission (see Section 2.30.16.4)

150. Systems Availability and Performance Report (see Section 2.30.16.5)

151. Business Continuity and Disaster Recovery Plan (see Section 2.30.16.6)

152. Reports on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee (see Section 2.30.17)

153. Subcontracted claims processing report (see Section 2.30.18.1)

154. Security Incident Report (see Section 2.30.19)

155. Summary Listings of Servicing Providers (see Section 2.30.20.1)

156. Supervisory Personnel Report (see Section 2.30.20.2)

157. Alleged Discrimination Report (see Section 2.30.20.3)

158. Non-discrimination policy (see Section 2.30.20.4)

159. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.20.5)

160. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1

161. Disclosure of conflict of interest (see Section 2.30.21)

162. Return of funds in accordance with Section 3.12.5

163. Termination plan in accordance with Section 4.4.7.2.8

ATTACHMENT IX
REPORTING REQUIREMENTS

ATTACHMENT IX, EXHIBIT A
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

ATTACHMENT IX, EXHIBIT A.1
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
SUMMARY REPORT
For the Quarter Ended **<INSERT DATE >**

Report Title:	**Members**	**Over (Under) Paid**
Premium Discrepancy Report	5	$ (419.61)
No Premium Report	2	(282.70)
No Eligibility Report	2	535.68
Total	9	$ (166.63)

Note: The first row of member detail on each report provides the detail the MCO has on file, based on information from eligibility files received from the State. This row also includes a calculation of the amount of premium/capitation payment expected. The second row (State Info) details the premium/capitation payment actually received from the State, per the monthly premium/capitation payment file.

Report Definitions

Calculated Age	The age of the member is calculated based on the Start Date, per the premium/capitation payment file received from the State, less the member's Date of Birth, per the eligibility information maintained by the MCO based on the eligibility files received. Neither the member's age nor the Date of Birth is on the premium file.
MCO Effective Date	The date the MCO has the member effective. The source of this information is the eligibility file received from the State.
MCO Term Date	The date the MCO has the member termed. The source of this information is the eligibility file received from the State.
State Start Date	The starting date for which the State is paying premiums/capitation payments, per the premium file received from the State.
State End Date	The ending date for which the State is paying premiums/capitation payments, per the premium file received from the State.
Amount Expected	The expected amount of premium/capitation payment to be paid per reporting period, based upon eligibility information.

ATTACHMENT IX, EXHIBIT A.2
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
PREMIUM/CAPITATION PAYMENT DISCREPANCY REPORT
For the Quarter Ended **<INSERT DATE >**

MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	County	Program Code	Effective Date	Term Date	Amount Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	County	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
	Smith, John	444-33-1111	08/24/66	41	M	2	87	8/1/07	8/31/07	96.40	
	Smith, John	444-33-1111			M	2	17	8/1/07	8/31/07	14.84	(81.56)
	Smith, Jane	444-33-2222	07/13/67	39	F	2	67	7/1/06	12/31/06	714.54	
	Smith, Jane	444-33-2222			F	2	67	7/1/07	8/15/07	357.27	(357.27)
	Jones, Alice	444-33-3333	06/25/57	44	F	4	87	7/1/06	12/31/06	475.41	
	Jones, Alice	444-33-3333			F	4	87	7/1/07	9/30/07	899.10	423.69
	Jones, Steve	444-33-4444	09/30/72	28	M	3	97	8/1/05	12/31/05	508.09	
	Jones, Steve	444-33-4444			M	4	97	8/1/07	9/30/07	501.76	(6.28)
	Robertson, Pat	444-33-5555	11/11/76	22	F	1	67	4/1/05	12/31/05	682.08	
	Robertson, Pat	444-33-5555			M	1	67	7/1/07	9/30/07	283.89	(398.19)

ATTACHMENT IX, EXHIBIT A.3
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
NO PREMIUM/CAPITATION PAYMENT REPORT
For the Quarter Ended **<INSERT DATE >**

										Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	County	Program Code	Start Date	End Date	Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	*County*	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
	Doe, John	555-44-3333	09/29/39	54	M	2	17	1/1/00	12/31/06	44.52	
	-	-			-	-	-	-	-	0.00	(44.52)
	Doe, Jane	555-44-4444	01/18/52	49	F	2	67	9/1/07	9/30/07	238.18	
	-	-			-	-	-	-	-	0.00	(238.18)

ATTACHMENT IX, EXHIBIT A.4
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
NO ELIGIBILITY REPORT
For the Quarter Ended **<INSERT DATE >**

										Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	County	Program Code	Start Date	End Date	Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	*County*	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
-	-	-	-	-	-	-	-	-	-	0.00	
Jones, John	777-66-5555				M	1	67	7/1/07	7/31/07	94.63	94.63
-	-	-	-	-	-	-	-	-	-	0.00	
Jones, Jane	777-66-6666				F	3	97	7/1/07	7/31/07	441.05	441.05

ATTACHMENT IX, EXHIBIT B
MENTAL HEALTH CASE MANAGEMENT REPORT

ATTACHMENT IX, EXHIBIT B
MENTAL HEALTH CASE MANAGEMENT REPORT

The *Mental Health Case Management Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for appointments scheduled within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility
3. Number and percentage of compliance for appointments occurring within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility, excluding member no shows, reschedules, and refusals
4. Number and percentage of appointment no shows
5. Number and percentage of appointment reschedules
6. Number and percentage of members meeting medical necessity for mental health case management and refusing the service
7. Data elements #2 - #6 broken down by mental health case management agency
8. DCS status

ATTACHMENT IX, EXHIBIT C
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

ATTACHMENT IX, EXHIBIT C
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

The *Behavioral Health Crisis Response Report* required in Section 2.30.4.4 shall include, at a minimum, the following data elements:

1. Number of calls by age category (18 and over/under 18)
2. Total Number of calls
3. Average response time for face to face interventions by level of acuity
4. Number of calls by payer source (TennCare/Non-TennCare)
5. Number of calls by level of acuity
6. Number of consumers whose behavioral health provider was notified of crisis situation
7. Location of face to face intervention
8. Total number of face-to-face contacts
9. Final disposition
10. Number per type of barrier to diversion from inpatient admission
11. Average time for admission to crisis respite

ATTACHMENT IX, EXHIBIT D
MEMBER CRG/TPG ASSESSMENT REPORT

ATTACHMENT IX, EXHIBIT D
MEMBER CRG/TPG ASSESSMENT REPORT

The *Member CRG/TPG Assessment Report* required in Section 2.30.4.5 shall include, at a minimum, the following data elements:

CRG assessment of members age 18 years or older

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's birth date
5. Member's Social Security Number (SSN)
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Measure of member's level of functioning in activities of daily living
9. Measure of member's level of functioning in interpersonal functioning
10. Measure of member's level of functioning in concentration, task performance, and pace
11. Measure of member's level of functioning in adaptation to change
12. Measure of member's severity of impairment
13. Measure of member's duration of mental illness
14. Indicator of member's former severe impairment
15. Member's need for services to prevent relapse
16. Member's Clinically Related Group (CRG)
17. Reason for assessment
18. Date of request for assessment
19. Date of CRG assessment
20. Measure of rater's adequacy of information in order to complete assessment
21. Member's current Global Assessment of Functioning (GAF) scale score
22. Member's highest GAF scale score (past year)
23. Member's lowest GAF scale score (past year)
24. Program code
25. Rater's TennCare provider ID number

TPG assessment of members under age 18

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's date of birth
5. Member's social security number
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Member's current Global Assessment of Functioning (GAF) scale score
9. Member's highest GAF scale score (past year)
10. Member's lowest GAF scale score (past year)
11. Severity of impairment
12. Serious Emotional Disturbance (SED) status
13. Environmental issues
14. Family issues
15. Trauma issues
16. Social skills issues
17. Abuse/neglect issues
18. Child at risk of SED

19. Member's Target Population Group (TPG)
20. Reason for assessment
21. Date of request for assessment
22. Date of TPG assessment
23. Measure of rater's adequacy of information in order to complete assessment
24. Program code
25. Rater's TennCare provider ID number

ATTACHMENT IX, EXHIBIT E
PROVIDER ENROLLMENT FILE

ATTACHMENT IX, EXHIBIT E
PROVIDER ENROLLMENT FILE

[INTENTIONALLY LEFT BLANK]

ATTACHMENT IX, EXHIBIT F
PCP ASSIGNMENT REPORT

ATTACHMENT IX, EXHIBIT F
PCP ASSIGNMENT REPORT

The CONTRACTOR shall use the following grid to complete the *PCP Assignment Report* required in Section 2.30.7.3.

MCO NAME: **REPORTING PARTY:** **TELEPHONE # :**		**REPORTING PERIOD:** **QTR 1 QTR 2 QTR 3 QTR 4** (Please circle)	
QTR	**Numerator: Members not assigned to a PCP within 30 days of enrollment** or prior to the member's beginning effective date **by Grand Region during the reporting period**	**Denominator: Total number of new members in the Grand Region during the reporting period**	**Rate**
1/1- 3/31			
4/1-6/30			
7/1-9/30			
10/1-12/31			

ATTACHMENT IX, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES

ATTACHMENT IX, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES

Instructions for Completing *Report of Essential Hospital Services*

The chart for the *Report of Essential Hospital Services* required in Section 2.30.7.4 is to be prepared based on the CONTRACTOR's provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.

- Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.

1. In the first column, "Name of Facility" indicate the complete name of the facility.

2. In the second column: "City/Town" indicate the city or town in which the designated facility is located.

3. In the third column: "County", indicate the name of the county in which this facility is located.

4. In the fourth through the tenth columns indicate the status of the CONTRACTOR's relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, and Centers of Excellence for Behavioral Health. For example:

   - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an "E" in the column labeled "Neonatal".

   - If the CONTRACTOR does not have an executed provider agreement with this facility for "Neonatal", but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.

   - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled "neonatal" blank.

ATTACHMENT IX, EXHIBIT G
ESSENTIAL HOSPITAL SERVICES REPORT

MCO Name:_____

Grand Region: _____

Number of TennCare Members:_____

as of (date): _____

Name of Facility	City/Town	County	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Center of Excellence for Behavioral Health	Comments

E = Executed Provider Agreement
L = Letter of Intent
R = On Referral Basis
N = In Contract Negotiations
O = Other Arrangement
If no relationship for a particular service leave cell blank

ATTACHMENT IX, EXHIBIT H
FQHC REPORT

ATTACHMENT IX, EXHIBIT H
FQHC REPORT

MCO Name: _____

As of January 1, _____

Please provide the information identified below for each FQHC with which the MCO has a provider agreement.

1. FQHC Name: _____
2. FQHC Address: _____
   _____

3. Total Amount Paid for the previous twelve (12) month period from July 1 through June 30: _____

ATTACHMENT IX, EXHIBIT I
SINGLE CASE AGREEMENTS REPORT

ATTACHMENT IX, EXHIBIT I
SINGLE CASE AGREEMENTS REPORT

MCO Name:_____
Month/Year:_____

Date of Agreement	Name of Member	Name of Provider	Specialty	Service Reason	Amount to be Paid

ATTACHMENT IX, EXHIBIT J
COST AND UTILIZATION REPORTS

ATTACHMENT IX, EXHIBIT J.1

[MCO NAME]
Physical Health Cost & Utilization Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Claims Health Care Expense										
Classified Health Care Expense										
Inpatient										
Outpatient										
Total Practitioner										
R.A.P. – Hospital Based										
Primary Care										
Specialist										
Total Miscellaneous										
Transportation										
Total Capitation										
Vendor A										
Vendor B										
Vendor C										
Vendor D										
Vendor E										

ATTACHMENT IX, EXHIBIT J.2

[MCO NAME]
Physical Health Inpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Inpatient										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										
Medical										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										
Surgical										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										
Obstetrical										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										

ATTACHMENT IX, EXHIBIT J.3

[MCO NAME]
Physical Health Outpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Outpatient										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Surgery										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
ER-Emergency										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
ER Non-Emergency										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Diagnostic										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Other Services [MCO to id what is here]										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										

ATTACHMENT IX, EXHIBIT J.4

[MCO NAME]
Physical Health Practitioner Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Payment PMPM										
Total Practitioner										
Radiology										
Anesthesiology										
Pathology										
Total R.A.P.										
Primary Care Adult										
Primary Care Child										
Primary Care Total										
OB-GYN										
Cardiology										
Dermatology										
Endocrinology										
Gastroenterology										
General Surgery										
Nephrology										
Neurology										
Neurosurgery										
Oncology/Hematology										
Ophthalmology/Optometry										
Orthopedic Surgery										
Otolaryngology										
Pulmonology										
Urology										
Emergency Medicine										
Other										
Total Specialist (excluding psychiatry)										
Total Primary & Specialty										
Visits Per 1,000										
Total Practitioner										
Radiology										
Anesthesiology										
Pathology										
Total R.A.P.										
Primary Care Adult										

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Primary Care Child										
Primary Care Total										
OB-GYN										
Cardiology										
Dermatology										
Endocrinology										
Gastroenterology										
General Surgery										
Nephrology										
Neurology										
Neurosurgery										
Oncology /Hematology/										
Ophthalmology/Optometry										
Orthopedic Surgery										
Otolaryngology										
Pulmonology										
Urology										
Emergency Medicine										
Other										
Total Specialist (excluding psychiatry)										
Total Primary & Specialty (excluding psychiatry)										

ATTACHMENT IX, EXHIBIT J.5

[MCO NAME]
Physical Health Miscellaneous Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Miscellaneous [MCO needs to id and adjust as appropriate]										
Payment PMPM										
Durable Medical Equipment										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Home Infusion Therapy										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Home Health Agency										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Orthotics/Prosthetics										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Vision Hardware										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Transportation - Emergency										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Transportation - NET										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Other										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										

ATTACHMENT IX, EXHIBIT J.6

[MCO NAME]
Behavioral Health Cost & Utilization Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Claims Behavioral Health Expenses											
Priority Behavioral Health Expenses											
Psychiatric Inpatient											
Psychiatric Residential											
Substance Abuse Inpatient											
Substance Abuse Inpatient Detox											
Substance Abuse Residential											
Total Mental Health Outpatient											
MD Services (Psychiatry)											
Non-MD Services											
Partial Hospital/IOP											
Total Substance Abuse Outpatient (including Detox)											
Substance Abuse Outpatient											
Substance Abuse Outpatient Detox											
Total Miscellaneous											
Lab											
Transportation											
Total Crisis Services											
Crisis Intervention											
Crisis Respite											
Crisis Stabilization											
Mental Health Case Management											
Total Psychiatric Rehabilitation											
Psychosocial											
Supported Employment											
Peer Support											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard	State Only & Judicial
Illness Management & Recovery											
Supported Housing											
Non-Priority Behavioral Health Expenses											
Psychiatric Inpatient											
Psychiatric Residential											
Substance Abuse Inptatient											
Substance Abuse Inpatient Detox											
Substance Abuse Residential											
Total Mental Health Outpatient											
MD Services (Psychiatry)											
Non-MD Services											
Partial Hospital/IOP											
Total Substance Abuse Outpatient (including Detox)											
Substance Abuse Outpatient											
Substance Abuse Outpatient Detox											
Total Miscellaneous											
Lab											
Transportation											
Total Crisis Services											
Crisis Intervention											
Crisis Respite											
Crisis Stabilization											
Mental Health Case Management											
Total Psychiatric Rehabilitation											
Psychosocial											
Supported Employment											
Peer Support											
Illness Management & Recovery											
Supported Housing											

ATTACHMENT IX, EXHIBIT J.7

[MCO NAME]
Behavioral Health Inpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Psychiatric Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Psychiatric Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Psychiatric Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Average Length of Stay											
Priority Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Total Substance Abuse Inpatient Detox											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Inpatient Detox											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Inpatient Detox											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Substance Abuse /Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Residential											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											

ATTACHMENT IX, EXHIBIT J.8

[MCO NAME]
Behavioral Health Outpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Mental Health Outpatient Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority MD Services (Psychiatry)											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority MD Services (Psychiatry)											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority Non-MD Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Non-MD Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Priority Partial Hospitalizations/IOP											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Partial Hospitalizations/IOP											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Total Substance Abuse Outpatient including detox											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority Substance Abuse Outpatient											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Substance Abuse Outpatient											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority Substance Abuse Outpatient Detox											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Substance Abuse Outpatient Detox											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											

ATTACHMENT IX, EXHIBIT J.9

[MCO NAME]
Behavioral Health Miscellaneous Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles / Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Miscellaneous											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Lab											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Lab											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Transportation											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Transportation											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

ATTACHMENT IX, EXHIBIT J.10

[MCO NAME]
Behavioral Health Specialized Community Services Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Crisis Services											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Crisis Intervention											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Crisis Intervention											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Crisis Respite											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Crisis Respite											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

Priority Crisis Stabilization											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Crisis Stabilization											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Total Mental Health Case Management											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Mental Health Case Management											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Mental Health Case Management											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Total Psychiatric Rehabilitation											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Psychosocial											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Psychosocial											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

Priority Supported Employment											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non Priority Supported Employment											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Peer Support											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Peer Support											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Illness Management & Recovery											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Illness Management & Recovery											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Supported Housing											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

Non-Priority Supported Housing											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

ATTACHMENT IX, EXHIBIT K
COST AND UTILIZATION SUMMARIES

ATTACHMENT IX, EXHIBIT K
COST AND UTILIZATION SUMMARIES

The quarterly *Cost and Utilization Summaries* required in Section 2.30.10.4 shall include information for each of the following populations:

- Medicaid
- Uninsured
- Medically Eligible
- Disabled
- Duals

Summaries for the following shall be provided:

1) Data elements for *Top 25 Providers (broken down by facilities, practitioners, ancillary providers, transportation providers) by Amount Paid*

    - Rank
    - Provider type
    - Provider Name
    - Street Address (Physical Location)
    - City
    - State
    - Zip Code
    - Amount Paid to Each Provider
    - Amount Paid as a Percentage of Total Provider Payments

2) Data elements for *Top 25 Inpatient Diagnoses by Number of Admissions*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Amount Paid
    - Admits
    - Admits as a Percentage of Total Admits

3) Data elements for *Top 25 Inpatient Diagnoses by Amount Paid*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Admits
    - Amount Paid
    - Amount Paid as a Percentage of Total Inpatient Dollars

4) Data elements for *Top 25 Outpatient Diagnoses by Number of Visits*

    - Rank
    - Diagnosis code
    - Description
    - Amount Paid
    - Visits

- Visits as a percentage of Total Outpatient Visits

5) Data elements for *Top 25 Outpatient Diagnoses by Amount Paid*

- Rank
- Diagnosis Code
- Description
- Visits
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Payments

6) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Number of Admissions*

- Rank
- DRG Code
- Description
- Amount Paid
- Number of Admissions
- Admissions as a Percentage of Total Admissions

7) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Amount Paid*

- Rank
- DRG Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

8) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Number of Procedures*

- Rank
- Procedure Code
- Description
- Amount Paid
- Number of Procedures
- Procedures as a Percentage of Total Surgical/Maternity Procedures

9) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Amount Paid*

- Rank
- Procedure Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

ATTACHMENT IX, EXHIBIT L
PRIOR AUTHORIZATION REPORTS

ATTACHMENT IX, EXHIBIT L.1
PRIOR AUTHORIZATION REPORT

REPORTING GRID (Children)

MCO NAME: REPORTING PARTY: TELEPHONE # :					REPORTING PERIOD: QTR 1 QTR 2 QTR 3 QTR 4 (Please Indicate QTR)
Service Types	**Total # Received**	**Total # Processed**	**Total # Approved**	**Total # Denied**	**Denial Reason(s) - Identify the # of denials for each denial reason indicated**
Inpatient (medical)					
Inpatient (psychiatric)					
Psychiatric RTF					
Home Health					
Private Duty Nursing					
Hospice					
Hospice (Institutional)					
Outpatient Surgery (Facility)					
Referrals (Specialist)					
Transportation					
Skilled Nursing Facility					

ATTACHMENT IX, EXHIBIT L.2
PRIOR AUTHORIZATION REPORT

REPORTING GRID (Adults)

MCO NAME: REPORTING PARTY: TELEPHONE # :					REPORTING PERIOD: QTR 1 QTR 2 QTR 3 QTR 4 (Please Indicate QTR)
Service Types	**Total # Received**	**Total # Processed**	**Total # Approved**	**Total # Denied**	**Denial Reason(s) - Identify the # of denials for each denial reason indicated**
Inpatient (medical)					
Inpatient (psychiatric)					
Home Health					
Private Duty Nursing					
Hospice					
Hospice (Institutional)					
Outpatient Surgery (Facility)					
Referrals (Specialist)					
Transportation					
Skilled Nursing Facility					

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND UTILIZATION MANAGEMENT PHONE LINE REPORT

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND UTILIZATION MANAGEMENT PHONE LINE REPORT

Instructions for Completing the *Member Services and Utilization Management Phone Line Report*

The following definitions shall be used:

Abandoned Call: A call in the phone line queue that is terminated by the caller before reaching a live voice.

Average Time to Answer: The average time that callers waited in the phone line queue (when the call was placed during the hours the phone line is open for services) before speaking to a MCO representative. This shall be reported in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

Call Abandonment Rate: The number of calls (where the member/provider called directly into the phone line or selected a member/provider services option and was put in the call queue) that are abandoned by the caller or the system before being answered by a live voice, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

Call Answer Timeliness: The number of calls (where the member called directly into the phone line or selected a member/provider services option and was put in the call queue) that are answered by a live voice within thirty (30) seconds, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND UTILIZATION MANAGEMENT
PHONE LINE REPORT

MCO Name:_____

Report Submission Date:_____

Reporting Quarter:_____

		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Nurse Triage Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Utilization Management Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			

ATTACHMENT IX, EXHIBIT N
MEDICAL LOSS RATIO REPORT

ATTACHMENT IX, EXHIBIT N
MEDICAL LOSS RATIO REPORT

Instructions for Completing the *Medical Loss Ratio Report*

The CONTRACTOR shall submit the *Medical Loss Ratio* Report (as required in Section 2.30.14.2.1) monthly. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings. A letter shall accompany this report from an actuary indicating that the reports, including the estimate for incurred but not reported expenses, have been reviewed for accuracy. A printed copy and electronic version of the report is to be submitted to the following:

Keith Gaither
Deputy Chief Financial Officer
Bureau of TennCare
Department of Finance and Administration
310 Great Circle Rd
Nashville, TN 37243

Email: keith.gaither@state.tn.us

John R. Mattingly
TennCare Examinations Director
Department of Commerce and Insurance
TennCare Division
500 James Robertson Parkway, Suite 750
Nashville, TN 37243-1169

Email: john.mattingly@state.tn.us

Instructions for completing the report:

- Enter the MCO name.
- Enter the reporting month.
- Enter the monthly number of **TennCare members**.
- Aggregate payments by **Grand Region** based on member residence.
- Each month report the amount of **Payments for Medical Services** made as of the effective date of the Agreement for services incurred through the end of the report month on a cumulative calendar year to date basis.
- Report the amount of **Payments by the Claims Processing System.** For Medical Services these payments should be reported by category of service.
- Report the amount of **Payments by the Claims Processing System** made for **CMS 1450** and **CMS 1500** claim types in the appropriate supporting triangle lag reports. The amounts entered into the triangle lag reports must tie to the amounts entered in the *Medical Loss Ratio Report - Total*. If a subcontractor processes transportation and/or other services then these payments should be reported on the Subcontractor Payments for Medical Services line and not entered into the triangle lag report. In addition, the CONTRACTOR shall reconcile the amount of **Payments by the Claims Processing System** made for **CMS 1450** and **CMS 1500** claim types to the amount paid as captured on the CONTRACTOR's encounter file submissions for the corresponding period. The format for the reconciliation shall be provided by TENNCARE.

- Report for each month the total amount of **Capitation Payments.** Capitation payments should include payments made directly to a service provider on a capitated basis.

- Report for each month the total amount of **Subcontractor Payments for Medical Services**. Subcontract payments should include payments made for services that are coordinated or arranged by a subcontractor. A description of each service and expenditure amount.

- Report for each month the total amount of **Reinsurance Payments**. Reinsurance payments are payments made to a licensed or authorized reinsurer to limit medical and hospital expenses by reducing maximum expenses on an individual basis, on an aggregate basis, or both.

- Report for each month the total amount of **Other Payments/Adjustments to Medical Costs**. Other payments may include settlements and claims payments made outside the claims processing system. Other payments/adjustments made for services incurred prior to the start date of operations must be excluded.

- Report for each month the total amount of **Grant Payments,** if applicable.

- Report for each month the amount of the **Crisis Services Team Pass Through.**

- Report for each month the total amount of **Recoveries Not Reflected in Payments by the Claims System**. Recoveries may include reinsurance payments, subrogation payments, and other settlement payments received. Details of the recoveries shall be provided in a supplemental schedule.

- The Excel spreadsheet calculates the **Total Payments for the Month**.

- Report the **Remaining IBNR for the Month**. The remaining IBNR is the estimated amount to be paid for services incurred through the report month but not yet reported. IBNR should not include estimated bonus payments, unless specifically accounted for in the provider's contract. A brief explanation of the IBNR estimate should be attached. All prior periods should be updated each month.

- The Excel spreadsheet calculates the **Payments and Remaining IBNR for the Month**.

- The Excel spreadsheet calculates the **Medical Loss Ratio** as Capitation Payments per Quarter (from TennCare) and Remaining IBNR divided by the Capitation Payments.

- Complete a separate Medical Loss Ratio report for base capitation only and the priority add-on payment. The 'Medical Loss Ratio Report – Base Capitation Only' should only reflect base capitation payments in revenue and payments for services excluding behavioral health services for Priority enrollees. The 'Medical Loss Ratio Report – Priority Add-On Only' should only reflect priority add-on payments in revenue and payments for behavioral health services for Priority enrollees. The 'Medical Loss Ratio Report – Total' should equal be equal to the Medical Loss Ratio Report – Base Capitation Only plus The Medical Loss Ratio Report – Priority Add-On.

ATTACHMENT IX, EXHIBIT N.1
MEDICAL LOSS RATIO REPORT

Medical Loss Ratio Report - Total
Grand Region

MCO														
Insert MCO Name														
Reporting Month		2007						For the Year Ended 6/30/2007	2007					
		Incurred Month							Incurred Month					
	Pr. To 1/07	January	February	March	April	May	June		July	August	September	October	November	December
Enrollment														
Capitation Revenue														
Payments for Covered Services for the Month														
Medical Services														
CMS 1450/UB 92 Payments by the Claims Processing System														
Inpatient - Maternity														
Inpatient - Newborn														
Inpatient -Medical														
Inpatient - Surgery														
Inpatient Other														
Outpatient - Emergency Room														
Outpatient - Laboratory														
Outpatient - Radiology														
Outpatient - Surgery														
Outpatient - Other														
CMS 1500 Payments by the Claims Processing System														
Prof - E&M														
Prof - Maternity														
Prof - Surgery														
Prof - DME														
Prof - Lab														
Prof - Radiology														
Prof - Transportation														
Prof - Other														
Capitation Payments														
Subcontractor Payments for Medical Services														
Other Medical (provide description)														
Behavioral Health														
Inpatient Payments by the Claims Processing System														
Outpatient Payments by the Claims Processing System														
Supported Housing Payments by the Claims Processing System														
Intensive Outpatient Payments by the Claims Processing System														
Partial Hospitalization Payments by the Claims Processing System														
In Home Payments by the Claims Processing System														
Transportation Payments by the Claims Processing System														
Twenty-Three Hour Payments by the Claims Processing System														
CMHA Capitation Payments														
Other Capitation Payments														
Grant Payments														
Non-FFS Inpatient														
Subcontractor Payments for Mental Health and Substance Abuse Services														
Crisis Services Team Pass Through														
Less:														
Recoveries not Reflected in Claims Payments														
Total Payments														
Remaining IBNR														
Payments and Remaining IBNR														
Medical Loss Ratio														
Per Member Expense														

ATTACHMENT IX, EXHIBIT N.1
MEDICAL LOSS RATIO REPORT

Medical Loss Ratio Report - Base Capitation Only
Grand Region

MCO														
Insert MCO Name														
Reporting Month		2007						For the Year Ended 6/30/2007	2007					
		Incurred Month							Incurred Month					
	Pr. To 1/07	January	February	March	April	May	June		July	August	September	October	November	December
Enrollment														
Capitation Revenue (For base capitation only)														
Payments for Covered Services for the Month														
Medical Services														
CMS 1450/UB 92 Payments by the Claims Processing System														
Inpatient - Maternity														
Inpatient - Newborn														
Inpatient -Medical														
Inpatient - Surgery														
Inpatient Other														
Outpatient - Emergency Room														
Outpatient - Laboratory														
Outpatient - Radiology														
Outpatient - Surgery														
Outpatient - Other														
CMS 1500 Payments by the Claims Processing System														
Prof - E&M														
Prof - Maternity														
Prof - Surgery														
Prof - DME														
Prof - Lab														
Prof - Radiology														
Prof - Transportation														
Prof - Other														
Capitation Payments														
Subcontractor Payments for Medical Services														
Other Medical (provide description)														
Behavioral Health (Excluding payments on behalf of Priority enrollees)														
Inpatient Payments by the Claims Processing System														
Outpatient Payments by the Claims Processing System														
Supported Housing Payments by the Claims Processing System														
Intensive Outpatient Payments by the Claims Processing System														
Partial Hospitalization Payments by the Claims Processing System														
In Home Payments by the Claims Processing System														
Transportation Payments by the Claims Processing System														
Twenty-Three Hour Payments by the Claims Processing System														
CMHA Capitation Payments														
Other Capitation Payments														
Grant Payments														
Non-FFS Inpatient														
Subcontractor Payments for Mental Health and Substance Abuse Services														
Crisis Services Team Pass Through														
Less:														
Recoveries not Reflected in Claims Payments														
Total Payments														
Remaining IBNR														
Payments and Remaining IBNR														
Medical Loss Ratio														
Per Member Expense														

ATTACHMENT IX, EXHIBIT N.1
MEDICAL LOSS RATIO REPORT

Medical Loss Ratio Report - Priority Add-On Only
Grand Region

MCO

Insert MCO Name

Reporting Month		2007						For the Year Ended 6/30/2007	2007					
		Incurred Month							Incurred Month					
	Pr. To 1/07	January	February	March	April	May	June		July	August	September	October	November	December
Enrollment (For Priority Enrollees Only)														
Capitation Revenue (Priority add-on payment only)														
Payments for Covered Services for the Month														
Medical Services														
CMS 1450/UB 92 Payments by the Claims Processing System														
Inpatient - Maternity														
Inpatient - Newborn														
Inpatient -Medical														
Inpatient - Surgery														
Inpatient Other														
Outpatient - Emergency Room														
Outpatient - Laboratory														
Outpatient - Radiology														
Outpatient - Surgery														
Outpatient - Other														
CMS 1500 Payments by the Claims Processing System														
Prof - E&M														
Prof - Maternity														
Prof - Surgery														
Prof - DME														
Prof - Lab														
Prof - Radiology														
Prof - Transportation														
Prof - Other														
Capitation Payments														
Subcontractor Payments for Medical Services														
Other Medical (provide description)														
Behavioral Health (On behalf of Priority enrollees only)														
Inpatient Payments by the Claims Processing System														
Outpatient Payments by the Claims Processing System														
Supported Housing Payments by the Claims Processing System														
Intensive Outpatient Payments by the Claims Processing System														
Partial Hospitalization Payments by the Claims Processing System														
In Home Payments by the Claims Processing System														
Transportation Payments by the Claims Processing System														
Twenty-Three Hour Payments by the Claims Processing System														
CMHA Capitation Payments														
Other Capitation Payments														
Grant Payments														
Non-FFS Inpatient														
Subcontractor Payments for Mental Health and Substance Abuse Services														
Crisis Services Team Pass Through														
Less:														
Recoveries not Reflected in Claims Payments														
Total Payments														
Remaining IBNR														
Payments and Remaining IBNR														
Medical Loss Ratio														
Per Member Expense														

ATTACHMENT IX, EXHIBIT N.2
CMS 1450 Payments by the Claims Processing System

Month Paid by the Claims System		Total	Prior to Jan-07	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
		Incurred Month of Service																																											
102,641	Jan-07	123,207	20,567	102,641																																									
1,390,011	Feb-07	1,397,549	7,538	1,277,436	112,575																																								
1,400,529	Mar-07	1,397,046	(3,483)	374,761	973,587	52,181																																							
1,538,049	Apr-07	1,539,089	1,040	160,992	348,987	1,014,047	14,024																																						
2,001,139	May-07	2,001,163	24	30,850	150,351	569,387	1,189,875	60,675																																					
2,036,767	Jun-07	2,036,767	0	35,029	61,188	273,447	582,938	1,039,330	44,834																																				
1,871,969	Jul-07	1,875,816	3,848	53,407	13,052	36,137	76,441	573,771	1,013,842	105,318																																			
1,357,234	Aug-07	1,357,234	0	18,788	12,958	156,125	40,600	116,648	269,898	688,651	53,567																																		
1,413,909	Sep-07	1,422,937	9,028	6,781	3,511	14,789	(3,231)	52,546	145,158	432,451	720,115	41,790																																	
1,498,241	Oct-07	1,498,241	0	615	279	20,931	38,358	33,995	116,021	112,256	353,581	808,119	14,086																																
3,556,603	Nov-07	3,556,603	0	494	(3,911)	28,804	22,781	8,345	16,781	635,370	517,427	1,023,113	1,166,241	141,157																															
1,813,104	Dec-07	1,813,104	0	10,587	14,419	(4,837)	14,688	26,962	7,194	35,228	86,031	99,288	415,192	1,038,164	70,187																														
1,670,936	Jan-08	1,670,936	0	(79)	(261)	(2,184)	48,019	26,745	4,471	11,584	35,362	25,194	160,313	375,211	947,733	38,828																													
2,420,889	Feb-08	2,421,959	1,070	1,242	10,824	17,181	6,400	70,185	4,594	2,777	3,990	60,895	136,793	170,616	647,970	1,168,790	118,634																													
1,878,065	Mar-08	1,878,065	0	897	3,772	(1,072)	(177)	(288)	3,071	8,267	41,055	225,216	31,100	38,261	148,391	465,675	899,830	14,068																											
3,184,573	Apr-08	3,184,573	0	(191)	1,874	2,996	(1,311)	4,102	4,709	6,284	2,662	21,512	10,270	41,129	219,338	247,123	892,758	1,549,711	181,606																											
2,303,770	May-08	2,303,770	0	(3,824)	(119)	(216)	(4,929)	(700)	1,261	14,105	(5,651)	4,278	10,374	13,304	128,073	125,515	235,464	514,055	1,166,110	105,671																										
1,516,584	Jun-08	1,516,584	0		975	185	524	(4,373)	250	941	728	(292)	1,620	13,662	23,431	12,753	35,784	101,292	258,634	1,013,387	57,084																									
2,222,204	Jul-08	2,222,204	0	80	80	(4)	0	(19)	(152)	1,039	(3,061)	13	13,607	709	182,034	4,413	81,590	75,546	176,518	327,680	1,232,445	129,684																								
2,387,471	Aug-08	2,387,471	0	(13)	(300)	114	(821)	(606)	(81)	(92)	(669)	(595)	2,609	6,979	7,174	6,233	4,006	456,013	60,162	197,131	361,646	1,207,347	81,236																							
2,504,634	Sep-08	2,504,634	0		(21)	845		456	(408)	20,084	19,411	16,164	2,306	31,469	2,487	135,073	47,835	83,913	16,111	72,769	162,136	601,531	1,190,664	101,811																					
2,358,341	Oct-08	2,358,341	0	(1,138)	(1,900)	(807)	(4,162)	(2,655)	(2,492)	(4,287)	4,284	(8,065)	8,957	36,905	13,817	5,197	3,930	4,165	33,148	53,291	69,559	128,585	537,964	1,311,326	172,720																				
1,818,059	Nov-08	1,818,059	0		(577)	(1,269)	(236)	4,350	(599)	725	789	708	(2,972)	74	633	17,265	21,464	20,361	1,959	4,661	66,749	155,292	122,195	231,696	1,114,737	60,054																			
1,877,089	Dec-08	1,877,089	0	38	85	0	38	(134)	436	(31)	170	8,900	668	4,955	519	28,019	9,040	20,169	5,057	967	24,836	119,679	59,430	77,780	343,697	1,127,488	45,282																		
2,184,885	Jan-09	2,184,885	0	(395)	0		(1,200)	(6,792)	(482)	125	(263)	(3,443)	(878)	328	(696)	11,911	1,506	19,855	690	117,162	(378)	45,809	54,017	64,689	180,572	488,457	1,122,939	91,352																	
2,383,775	Feb-09	2,383,775	0	(48)		0	22		(78)	0	0	(520)	395	(2,197)	(3,073)	(1,174)	(2,384)	(4,217)	238	1,139	(673)	43,274	27,873	21,946	88,850	252,904	603,867	1,287,489	70,143																
1,812,451	Mar-09	1,812,451	0	(5,046)		0				2,324	375	(217,849)	238	(17,810)	(10,103)	(10,270)	33	(756)	(925)	(1,193)	3,780	156,823	7,360	22,940	43,428	62,846	173,442	354,362	1,227,326	21,126															
2,890,996	Apr-09	2,890,996	0			(361)	(31)	(393)		(1,800)	364	(207)	(842)	(118)	(395)	(7,613)	(11,714)	2,184	2,291	3,003	3,904	9,364	217,250	114,812	29,594	47,601	87,888	127,476	725,829	1,418,727	124,184													
2,170,849	May-09	2,170,849	0	(225)		(100)		(188)	1,300	(114)	0	(769)	0	0	(1,888)	0	2,418	(487)	6,519	28,368	(2,981)	944	5,201	14,724	27,959	11,729	40,208	38,213	138,319	653,398	1,153,708	54,592													
2,868,999	Jun-09	2,868,999	0	(12,077)	(13,430)	(13,799)	(16,337)	(15,513)	(16,078)	(15,819)	(14,101)	(15,193)	(13,980)	(13,575)	(15,983)	(17,441)	(19,382)	(14,573)	(15,736)	(10,979)	(24,471)	(14,168)	(8,477)	(2,046)	85,816	14,072	340,251	147,044	188,989	263,712	858,694	1,202,549	71,040												
2,423,385	Jul-09	2,423,385	0			0				0		2,850	2,718	(19)	0		(320)	127	99,087	5,313	13,846	5,738	1,949	1,992	11,400	51,311	38,609	135,488	48,747	72,881	165,822	682,066	1,049,238	34,543											
2,844,587	Aug-09	2,844,587	0					134	0	0				(550)		0	(96)	0	(2,431)	(86)	(2,226)	3,346	9,748	16,209	42,801	1,448	65,249	28,341	74,922	25,519	200,233	213,674	957,170	1,174,079	37,105										
2,817,010	Sep-09	2,817,010	0		(151)	38			503	48	(1,255)	(449)	114	2,171		0	(1,180)	(2,000)	0	48	526	0	100,048	(312)	8,081	4,506	(564)	34,786	129,282	114,071	131,742	118,089	122,958	920,503	1,107,392	28,014										
3,885,472	Oct-09	3,885,472	0	0	(1,280)				241	300			(76)			0		(464)	100	(6,664)	0	3,946	18,614	53	(3,578)	(573)	19,655	10,211	121,540	47,763	223,212	81,374	170,770	631,561	1,090,217	1,419,198	59,350									
2,935,716	Nov-09	2,935,716	0			1,726				0		2,052			76	0	5,879		635	297	0	(1,449)	51	5,243	3,679	10,143	5,472	23,058	35,065	44,339	26,824	76,022	133,331	126,576	271,858	750,036	1,367,141	47,663							
2,827,098	Dec-09	2,827,098	0	0		(51)		(109)			(1,279)	(327)	0						0	2,400	142	236	78	151	35,014	106	(430)	5,765	4,490	37,842	21,478	25,270	98,867	64,300	199,357	324,439	897,640	1,088,490	23,230						
3,970,747	Jan-10	3,970,747	0									0			0	(76)		(141)	71	1,425	70	286	73	(135)	3,128	443	1,573	2,734	67,047	18,082	(24,086)	44,568	96,947	75,710	180,835	115,569	474,391	1,255,210	1,588,142	68,880				
3,457,830	Feb-10	3,457,830	0											0		0		3,096	19,775	0	133	336	231	560	(673)	891	361	1,576	(1,213)	59,587	18,472	42,558	12,443	99,166	75,824	113,588	218,061	305,032	954,651	1,469,531	63,844			
2,845,624	Mar-10	2,845,624	0			(208)		60		(1,137)	(1,470)		(96)		5,060				(1,860)	(1,614)	(1,422)	(954)	(1,850)	779	(2,560)	(2,491)	(612)	(7,243)	(7,169)	(1,828)	(1,808)	(11,639)	(822)	19,199	37,363	71,607	206,603	(16,737)	240,536	846,075	1,403,929	77,933		
3,021,773	Apr-10	3,021,773	0												0					0			0	223	582	660	(922)	10,216	5,279	(76)	55,850	12,518	15,055	13,195	29,569	25,975	160,409	91,803	101,688	223,653	961,190	1,212,824	102,083	
3,211,499	May-10	3,211,499	0	0													0	0	0			0	1,520	0	(76)	86	4,874	943	1,910	2,492	3,793	3,025	2,928	53,524	(5,181)	92,219	97,811	201,859	189,717	173,497	310,389	638,728	1,376,870	60,572	
3,626,133	Jun-10	3,626,133	0	24							114						114					48	(114)	2,400	14,019	483	94	743	511	7,308	2,944	10,352	18,052	1,879	32,272	7,250	21,335	46,904	323,002	159,220	141,824	132,648	859,142	1,655,399	188,166
Totals		98,341,273	39,630	2,051,627	1,686,569	2,164,023	2,002,271	1,986,401	1,614,327	2,054,596	1,812,277	2,092,384	1,958,759	1,880,824	2,365,775	2,230,220	2,325,206	2,841,917	2,007,759	1,914,175	1,964,705	2,595,698	2,425,060	1,986,843	2,199,189	2,132,165	2,547,234	2,292,553	2,831,018	2,784,944	2,961,062	2,555,019	2,747,978	3,214,234	3,056,610	2,947,896	3,502,741	3,020,224	3,420,965	2,940,857	2,881,175	2,062,132	2,338,094	1,715,970	188,166

FY 10	20,133,606
FY 09	32,045,225
FY 08	26,142,616
FY 07	19,980,196

98,341,273 Total for Dates of Service after 1/1/2007

ATTACHMENT IX, EXHIBIT N.3
CMS 1500 Payments by the Claims Processing System

Month Paid by the Claims System		Total	Prior to Jan-07	Incurred Month of Service Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
62,077	Jan-07	63,829	1,752	62,077																																									
1,322,171	Feb-07	1,326,517	4,346	1,154,878	167,293																																								
1,557,207	Mar-07	1,558,613	1,406	394,464	1,078,194	94,549																																							
1,635,356	Apr-07	1,636,068	713	129,683	423,246	1,017,855	64,572																																						
2,208,817	May-07	2,209,919	1,102	78,433	162,815	571,542	1,237,594	158,432																																					
1,718,864	Jun-07	1,719,584	720	19,048	58,913	105,160	457,887	934,722	143,135																																				
1,983,763	Jul-07	1,983,763	0	10,870	26,097	54,322	158,656	456,856	1,041,330	235,631																																			
1,793,839	Aug-07	1,793,934	95	8,619	7,131	13,378	63,229	153,365	393,808	981,587	172,723																																		
1,863,463	Sep-07	1,863,566	103	5,227	14,683	14,926	24,488	53,415	150,544	421,099	1,011,925	167,157																																	
1,887,286	Oct-07	1,887,286	0	14,175	6,885	9,604	20,401	15,745	47,127	153,640	367,664	1,152,086	99,960																																
2,364,287	Nov-07	2,364,287	0	2,257	533	3,532	4,216	9,612	33,106	116,169	204,494	553,549	1,246,567	190,252																															
1,876,238	Dec-07	1,876,205	(33)	2,194	1,778	4,370	4,534	8,202	8,021	24,248	38,626	109,844	402,466	1,111,665	160,289																														
1,718,344	Jan-08	1,718,344	0	(3,246)	(3,048)	170	955	5,527	2,709	6,221	18,049	54,879	136,770	356,846	1,056,262	86,250																													
2,364,591	Feb-08	2,364,591	0	1,415	237	2,147	1,781	9,046	8,867	(1,852)	(560)	5,936	62,376	192,005	528,762	1,352,404	202,028																												
2,097,183	Mar-08	2,097,183	0	1,569	11,643	8,729	14,852	10,457	23,665	37,620	29,717	31,139	39,904	62,492	109,617	425,721	1,162,715	127,342																											
2,480,764	Apr-08	2,480,764	0	3,596	3,994	6,044	3,518	6,630	1,711	825	(2,065)	7,303	8,077	13,790	55,519	129,746	520,453	1,400,232	321,389																										
2,197,467	May-08	2,197,467	0	(8,994)	192	(133)	(620)	(391)	(123)	4,793	(2,930)	6,074	1,830	6,272	25,026	53,952	175,821	391,638	1,329,291	215,771																									
1,799,772	Jun-08	1,799,772	0	(75)	(105)	1,585	1,111	(1,533)	656	1,072	3,357	2,001	2,178	800	21,209	5,412	50,533	141,882	310,905	1,060,804	197,979																							
2,319,568	Jul-08	2,319,568	0	477	710	1,054	4,676	257	(432)	151	(101)	678	186	7,941	5,431	6,437	20,193	69,713	215,668	458,086	1,314,835	213,608																							
2,063,218	Aug-08	2,063,591	373	5,068	4,055	41	193	83	(6)	157	(1,165)	8,390	7,071	1,388	2,727	5,391	791	40,764	41,321	109,553	416,222	1,219,605	201,567																						
2,046,212	Sep-08	2,046,212	0	419	606	23	1,872	628	(803)	(589)	(2,268)	(2,144)	2,563	7,428	(417)	9,948	15,171	21,038	23,782	59,731	127,604	379,961	1,186,407	215,249																					
2,442,187	Oct-08	2,441,874	(314)	(877)	(304)	(558)	(711)	(130)	(1,951)	(447)	(2,062)	(3,331)	4,007	2,393	3,645	3,168	4,656	24,942	10,434	18,570	75,469	174,421	444,590	1,419,631	266,633																				
1,994,508	Nov-08	1,994,508	0	(287)	(707)	(335)	23	148	878	4,414	1,847	2,303	1,980	2,301	7,418	7,152	1,633	6,700	6,343	13,193	37,504	71,898	127,708	378,756	1,155,245	168,392																			
1,884,204	Dec-08	1,884,204	0	38	(145)	(103)	(293)	(138)	244	(160)	225	419	1,107	(988)	113	657	2,418	4,945	3,179	4,683	8,835	26,258	61,834	136,807	376,865	1,132,093	125,309																		
2,604,533	Jan-09	2,604,533	0	(805)	(99)	4,701	(301)	(894)	(879)	(430)	(2,670)	(1,489)	558	710	1,558	4,436	10,905	14,772	19,668	21,758	27,302	24,728	40,754	96,604	205,285	525,845	1,397,725	214,794																	
2,146,477	Feb-09	2,146,477	0	(79)	(129)	57	(6)	68	(53)	85	501	2,236	4,316	6,713	7,705	5,137	6,236	8,494	8,439	2,448	14,141	12,406	9,950	29,851	85,338	147,128	379,990	1,220,455	195,046																
2,081,571	Mar-09	2,081,571	0	877	3,342	8,266	4,519	3,416	2,505	2,401	4,171	4,015	(11,010)	2,137	7,437	5,030	916	2,044	734	(70)	2,204	2,178	5,732	14,684	20,746	85,563	161,075	388,323	1,276,512	83,826															
2,555,559	Apr-09	2,555,559	0	(99)	0	(455)	(464)	(60)	(26)	490	378	433	670	438	991	(1,377)	(1,667)	(334)	52	6,828	5,430	813	12,307	12,665	12,955	22,473	97,006	204,480	545,697	1,429,214	206,721														
2,062,110	May-09	2,062,110	0	(158)	0	(84)	0	(146)	(502)	(726)	(172)	(268)	(30)	(742)	(2,213)	2,866	176	260	(1,063)	(750)	(2,645)	(688)	2,107	7,821	5,381	12,827	29,294	66,476	113,529	433,061	1,231,121	167,378													
2,265,262	Jun-09	2,265,262	0	(5)	(30)	(243)	(175)	354	(178)	544	(14)	(450)	(17)	417	3,215	(1,383)	(1,425)	(1,349)	(796)	(926)	(1,761)	1,509	344	10,097	8,981	13,897	15,386	28,389	126,321	186,428	464,584	1,210,499	203,048												
2,040,013	Jul-09	2,040,013	0	388	212	145	33	(209)	(108)	(29)	(151)	(117)	(405)	(103)	(143)	(61)	(623)	173	233	(259)	2,125	946	3,535	4,265	(211)	6,158	9,730	18,521	52,508	91,084	212,451	535,744	985,162	119,020											
2,220,604	Aug-09	2,220,604	0	0	85	159	0	10	(208)	(5)	0	0	143	76	0	132	(130)	(144)	(2,649)	(1,406)	(730)	939	5,468	(7,066)	2,940	6,605	17,099	10,674	15,752	32,691	88,216	180,392	665,452	1,113,663	92,466										
2,252,066	Sep-09	2,252,066	0	0	(280)	0	(82)	0	94	336	(240)	(80)	263	983	57	0	(294)	(329)	(1,301)	(831)	520	1,399	(104)	2,303	(494)	(646)	3,972	5,517	9,014	23,646	36,092	86,981	181,740	711,971	1,104,523	87,337									
2,751,305	Oct-09	2,751,305	0	146	(717)	(35)	0	(66)	46	199	0	116	(74)	21	(469)	74	0	(336)	(103)	(51)	127	1,445	62	(563)	(3,684)	(1,735)	800	5,186	9,999	17,329	10,309	24,542	104,899	253,640	744,300	1,408,349	177,549								
2,263,850	Nov-09	2,263,850	0	0	(16)	81	0			0		(440)	0	50	257	(1,242)	(11)	122	452	(129)	1,309	342	6,003	1,900	1,275	1,240	10,814	(2,163)	3,434	18,805	27,416	19,475	52,449	84,229	169,153	519,165	1,195,331	154,549							
2,210,655	Dec-09	2,210,655	0	(99)	83	(144)	0	(158)			(1,781)	0	0	(13)	0	1,321	67	(16)	(182)	20	(13)	0	(40)	252	99	181	1,001	3,210	(3,823)	1,131	10,157	8,555	11,847	15,072	107,269	188,976	596,826	1,180,932	89,925						
3,063,438	Jan-10	3,063,438	0	0	58	(61)	(232)		143	0		(94)	28	0	0	(163)	(3)	(15)	(30,589)	215	154	865	1,038	761	690	1,116	2,313	1,989	4,711	20,673	14,496	11,209	12,151	33,395	51,131	152,388	273,508	856,940	1,497,036	157,566					
2,283,695	Feb-10	2,283,695	0	0	0	(60)	(5)	(96)	(70)		0	167	(5)	(87)	0	(5)	428	(3)	(9)	(10)	8	343	294	(487)	(50)	(257)	599	916	182	2,328	2,461	11,032	8,233	15,238	8,822	34,681	88,742	146,389	531,319	1,297,189	135,469				
2,582,015	Mar-10	2,582,015	0	0	0	(61)		19	(2)	(119)	(35)	52	237	(10)	0	(108)	0	(96)	(246)	(544)	(1,007)	(1,111)	200	1,253	(855)	(542)	3,751	(6,329)	(1,647)	2,979	245	(5,737)	7,996	13,896	17,671	19,967	38,365	84,683	178,220	661,540	1,418,732	150,661			
2,254,135	Apr-10	2,254,135	0	(46)	0	0	0		(38)		0		0		(46)	0	(218)	(40)	(12)	(92)	0	(202)	0	247	143	171	276	2,384	58	5,065	2,755	3,394	2,089	5,014	3,070	9,145	15,045	33,225	73,483	157,594	651,590	1,140,596	149,484		
2,384,881	May-10	2,384,881	0	(15)		0	0	0	0		(10)	46	0	(106)	0	0	(74)	0	(63)	0	0	203	37	75	97	197	1,129	822	149	319	952	784	3,202	2,039	3,588	9,100	8,817	8,962	34,161	94,517	202,063	601,703	1,272,133	140,051	
2,523,845	Jun-10	2,523,845	0	38	(14)	72	(68)			0	137	87	0	0	0	(10)	84	(223)	0	(226)	(153)	114	(146)	68	(59)	221	387	114	17	645	(158)	234	22	304	704	4,761	9,038	10,997	20,821	37,444	97,705	140,079	558,829	1,380,995	260,987
Totals		88,237,664	10,263	1,871,172	1,967,190	1,920,237	2,066,154	1,823,171	1,853,211	1,987,323	1,837,593	2,100,499	2,011,716	1,965,069	1,993,951	2,100,883	2,170,782	2,252,177	2,254,877	1,966,365	2,225,460	2,131,999	2,109,651	2,325,175	2,137,320	2,120,928	2,257,655	2,163,757	2,347,459	2,349,224	2,307,817	2,254,482	2,238,269	2,367,480	2,302,698	2,433,870	2,403,221	2,476,676	2,424,966	2,405,850	2,505,559	2,033,038	1,980,446	1,521,046	260,987

FY 10	15,092,009
FY 09	27,454,005
FY 08	25,408,019
FY 07	20,273,369

88,237,664 Total for Dates of Service after 1/1/2007

ATTACHMENT X
CAPITATION RATES

ATTACHMENT X

CAPITATION RATES
EFFECTIVE APRIL 1, 2007 THROUGH JUNE 30, 2008

Aid Category	Age Group	Per Member Per Month
Medicaid (TANF & Related)	Age Under 1	$ 431.76
	Age 1 - 13	$ 75.52
	Age 14 - 20 Female	$ 207.32
	Age 14 - 20 Male	$ 96.29
	Age 21 - 44 Female	$ 327.13
	Age 21 - 44 Male	$ 283.06
	Age 45 - 64	$ 547.63
	Age 65+	$ 306.81
Uninsured/Uninsurable	Age Under 1*	$ 431.76
	Age 1 - 13	$ 64.99
	Age 14 - 19 Female	$ 105.69
	Age 14 - 19 Male	$ 90.59
Disabled	Age <21	$ 574.14
	Age 21+	$ 648.55
Medicaid/Medicare Duals	All Ages	$ 67.82
Waiver/Medicare Duals	All Ages	$ 18.11
State Only & Judicials	All Ages	$ 451.54
Priority Add-On	Age <21	$ 384.28
	Age 21+	$ 474.73