CONTRACT #12
RFS # 318.65-205

Department of Finance & Administration
Bureau of TennCare

VENDOR:
QSource Center for Healthcare Quality

RECEIVED
MAY 14 2007
FISCAL REVIEW

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

May 7, 2007

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

Attention: Ms. Leni Chick

RE: Bureau of TennCare
Contracts Submitted for Fiscal Review

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee amendment #2 to QSource Center for HealthCare Quality, RFS 318.65-205. This competitively bid contract is being amended to strengthen reporting requirements and timelines. There is no term extension or additional funding associated with this amendment.

Additionally, the Managed Care Organizations for West and East Tennessee are being amended to provide the following modifications to current MCO language: (1) Clarify National Provider Identification (NPI) requirement consistent with CMS requirements; (2) Revise Network Adequacy Language to be consistent with Middle TN CRA; (3) Revise Department of Education language to be consistent with current policies for coordination with Department of Education, Project Teach and school based providers; (4) Clarify LEP provisions and Teen Newsletter requirement; (5) Modify reporting relative to PCP and emergency room visits, emergency department utilization, disease management and case management, nurse triage 24/7 line, remove Quality Improvement Activity (QIA) Grid due to NCAQ Accreditation being achieved, and NCQA Reports; (6) Add language for consistency with NCQA requirements; (7) Revise risk target evaluation periods from quarterly to annual, revise and clarify methodology for Targets and Bonus potential; (8) Extend term of agreement through June 30, 2008 to align with State Fiscal Year and add funding to support extension of term, and (9) Housekeeping revisions made for consistency throughout the Agreement.

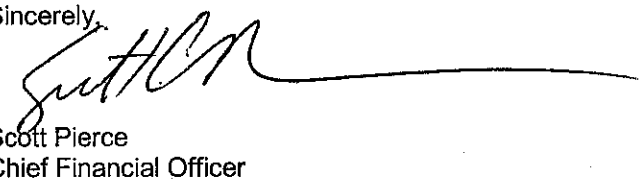
The Managed Care Organizations for Middle Tennessee are being amended to includes the following modifications: (1) Clarify National Provider Identification (NPI) requirements consistent with CMS requirements; (2) Revise language to be consistent with current policies for coordination with Department of Education, Project Teach and school based providers; (3) Clarify LEP provisions and Teen Newsletter requirements; (4) Modify reporting as it relates to PCP and emergency room visits; emergency department utilization, disease management and case management, nurse triage 24/7 line, and NCQA Reports; (5) Add language for consistency

with NCQA requirements, and (6) Housekeeping revisions made for consistency throughout the agreement.

The three Behavioral Health Organizations (BHOs) are being amended to provide the following modifications to BHO language: (1) Clarifies National Provider Identification (NPI) requirements consistent with CMS requirements; (2) Revise language to be consistent with current policies for coordination with Department of Education, Project Teach and school based providers; (3) Clarifies LEP provisions and Teen Newsletter requirement; (4) Strengthens reporting as it relates to case management services, inpatient reports, payment for out of plan emergency providers, cost and utilization, and satisfaction and outcome performance measures; (5) Clarifies language to require all provider agreements be approved in advance by TDCI; (6) Modification of mandatory evaluation time language to be consistent with Tennessee Code Annotated §33-7-303(b).; (7) Extends the term of the contract for an additional year and provides funding to support term extension, and (8) Housekeeping revisions made for consistency throughout the agreement.

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

REQUEST: NON-COMPETITIVE AMENDMENT

RECEIVED

MAY 14 2007

FISCAL REVIEW

APPROVED
Commissioner of Finance & Administration Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	318.65-205
2) State Agency Name :	Department of Finance and Administration, Bureau of TennCare
EXISTING CONTRACT INFORMATON	
3) Service Caption :	External Quality Review of TennCare MCO/BHO/DBM
4) Contractor :	QSource Center for Healthcare Quality
5) Contract #	FA-06-16559-00
6) Contract Start Date :	October 1, 2005
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	September 30, 2008
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$7,941,936.00
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	2
10) Proposed Amendment Effective Date : (attached explanation required if date is > 60 days after F&A receipt)	January 1, 2007
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	September 30, 2008
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$7,941,936.00

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

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

This amendment proposes no additional services for the Contractor to provide, however, it strengthens and supports reporting procedures and timelines. Additionally, specific language stipulates that designated staff assignments be delegated for the purpose of EQRO services as contained in this contract.

15) Explanation of Need for the Proposed Amendment :

The Bureau of TennCare is mandated by the Centers of Medicaid and Medicare Services (CMS) to provide comprehensive quality assurance and quality improvement programs, as well as External Quality Review. The language in this amendment provides for additional accountability by the Contractor by requiring timely and more detail specific reporting of these services.

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

Albert J. Grobmyer III, M.D., Chief Executive Officer
QSource Center for Healthcare Quality
3175 Lenox Park Blvd., Suite 309
Memphis, TN 38115

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

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

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

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

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

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

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

A Request for Proposal was released in July, 2005, to identify a contractor for External Quality Review for MCOs/BHOs and the DBM, at which time QSource Center for Healthcare Quality was awarded the contract. The language in this amendment was not part of the original procurement process, therefore this amendment is considered non-competitive.

21) Justification for the Proposed Non-Competitive Amendment :

After going through the competitive RFP process to identify a reliable, consistent contractor to perform External Quality Review for MCOs/BHOs/DBM, the Bureau of TennCare has now identified a need to incorporate stronger reporting language in this contract. The language in this amendment was not part of the original procurement process, therefore this amendment is considered non-competitive. No additional funding is required to support the reporting language included in this amendment.

REQUESTING AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)

M J Goetz II	5/2/07
Agency Head Signature	**Date**

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
318.65-205	FA-06-16559-02
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
QSource Center for Healthcare Quality	☐ C- or ☒ V- 620924699 00

Service Description

External Quality Review of TennCare MCO/BHO/DBM and HCBS

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
October 1, 2005	September 30, 2008	Vendor	93.778 Dept. of Health & Human Services/Title XIX

Mark, if Statement is TRUE

☒ Contractor is on STARS as required

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
318.65	042	083	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2006	$484,950.00	$1,454,829.00			$1,939,779.00
2007	$669,070.00	$2,007,212.00			$2,676,282.00
2008	$669,070.00	$2,007,212.00			$2,676,282.00
2009	$162,400.00	$487,193.00			$649,593.00
TOTAL	$1,985,490.00	$5,956,446.00			**$7,941,936.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2006	$1,939,779.00	
2007	$2,676,282.00	$0.00
2008	$2,676,282.00	$0.00
2009	$649,593.00	$0.00
TOTAL	**$7,762,116.00**	**$0.00**
End Date	**09/30/2008**	

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

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged

☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method

☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

AMENDMENT #2
TO FA-06-16559-00
BETWEEN THE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
QSOURCE CENTER FOR HEALTHCARE QUALITY

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the State or TennCare, and QSource Center for Healthcare Quality, hereinafter referred to as the Contractor, is hereby amended as follows:

1. Delete Section A.1.2.3.C. in its entirety and replace with the following:

   A.1.2.3.C. Perform analysis of existing and new Federal and State policies, procedures and regulations to determine their impact on the EQRO components of the TennCare program, and related State and Contractor-performed functions; analysis shall include a review of portions of the Federal Register that would impact the Bureau of TennCare. Annually provide a written impact analysis to the State with analysis of alternatives and recommendations for changes and enhancements to support the requirements; research and report annually on activities that other Medicaid EQROs have implemented.

2. Delete Section A.1.2.4.B in its entirety and replace with the following:

   A.1.2.4.B. Performing an annual quality survey of each MCC to determine contractual compliance, preparing a written report of findings, and forwarding said report to the State no later than 30 days after completion of the survey, unless otherwise agreed to in writing by the State. An annual survey shall be done to include measures that have been removed from accreditation standards, contractual requirements that are not fully duplicated in the NCQA survey or the ANA, and all criteria related to TennCare Court cases. Timelines associated with the annual quality survey include but are not limited to:

   - By January 31st Contractor shall submit the proposed review criterion to the State for approval.
   - By March 2nd, Contractor shall present the proposed schedule for the annual quality survey to the State for approval.
   - Appointments with the MCCs shall be scheduled 30 days in advance of visit.
   - The State shall be notified of any changes to the approved appointment schedule immediately.
   - An MCC specific draft report of the survey findings along with recommendations for improvement shall be provided to the State thirty (30) days from each MCC's onsite survey. The recommendations for improvement should include specific information the plans can utilize to make appropriate changes and, when appropriate, other state and national best practices. The final report shall be submitted to the State sixty (60) days following the review of each MCC.

   The Contractor shall develop review criteria to assess contract compliance and compliance with current industry, Federal, and State requirements for Medicaid managed care. Criteria must include, but not be limited to review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards and compliance with the appeal process. The survey process shall include: document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. Review, analysis, and recommendations for improvement of the MCC Structure and overall integration of the health care delivery system shall include but not be limited to, review and assessment of the following documents/activities listed below. After a health plan is NCQA accredited

all of the following requirements will not have to be reviewed if the criteria for each area has been fully reviewed by NCQA. Any deletions from the survey must be approved by TennCare.

1. MCC Structure
   a. Quality Improvement Program Description (QIPD)
   b. Utilization Management Program Description (UMPD)
   c. The associated work plans for the QIPD and UMPD
   d. The annual evaluation of the MCC Quality Improvement Program
   e. Adequacy of MCC's material resources and staffing
   f. Oversight of Quality Program by the MCC's governing body
2. Appropriate documentation of all committee meetings, i.e., Quality, Credentialing, and Peer Review
3. Oversight of all MCC's initial and recredentialing processes to include:
   a. Onsite credentialing file review
   b. Review of committee minutes
   c. Timeliness of credentialing/recredentialing process
   d. Incorporation of quality assessment (Site visit and medical record documentation practices)
   e. Assessment of quality of care and service issues which may include but not be limited to physician/provider specific confirmed and trended quality of care and service concerns, appeals data, over/under utilization data, and pharmacy utilization data
   f. MCC's process for medical record review of primary care physicians and high volume specialists
4. MCO/BHO Clinical Practice Guidelines
   a. Adoption, annual review, and dissemination of clinical practice guidelines to all appropriate network providers (at least four for MCOs and two for the BHOs)
   b. Guidelines shall be relevant to the MCC/BHO population
   c. Proof of annual measurement of at least two (2) indicators against each guideline is required
5. Audited Health Employer Data and Information Systems (HEDIS) and Consumer Assessment of Health Plan Surveys (CAHPS) data by MCC to validate opportunities for improvement and areas where meaningful improvement has been achieved (Customer Satisfaction survey for DBM)
6. MCO/BHO Quality Improvement Activities
   a. Clinical QIAs (at least three (3))
   b. Service QIAs (at least two (2))
7. MCO/BHO Disease Management Programs for the following components: (at a minimum Diabetes and Maternity Management Programs are required by the State for MCOs)
   a. Relevance to MCO/BHO population
   b. Consistency with nationally recognized clinical practice guidelines
   c. Assessment of member adherence to treatment plans
   d. Systematic identification of eligible population, initially and at least annually thereafter
   e. Program materials clearly provide information to members about how to use the services, how they were identified for participation, and how to opt in or out of the program
   f. Annual measurement of participation rates
   g. Interventions provided to enrollees based on stratification
   h. Providers are informed and educated about the program
   i. Program effectiveness is measured using at least one performance measure that is relevant, quantitative, population based, uses valid methodology, and has been analyzed against a benchmark or goal
8. MCC mechanism for identifying potential under/over utilization trends within provider network and actions taken when performance falls below established

standards

9. MCC process for review and update of medical necessity criteria
10. MCC process to ensure continuity and coordination of care
11. MCO/BHO case management services
    a. Selection criteria
    b. Available resources
    c. Penetration rate
    d. Turn-over rate (length of time in case management)
    e. Frequency of enrollee contact
    f. Evidence of network physician/provider participation
12. MCC UM denial files
13. MCO/BHO Home health denials – the number of files reviewed shall be of sufficient number to produce a statistically valid review
14. Adequacy of MCC provider networks
    a. Compliance with required access standards
    b. Compliance with required wait time standards
    c. Analysis of open/closed panels by MCC
    d. Compliance with established standards for appointment availability
15. MCC compliance with Call Center Standards
    a. Member Services
        i. Call answer timeliness
        ii. Call abandonment rate
    b. Health Services (Prior Authorization)
        i. Call answer timeliness
        ii. Call abandonment rate
        iii. Percent of calls returned within 24 hours
17. Appeal overturn rate by MCC
18. Accuracy and timeliness of MCC claims payment
19. Comparative analysis of MCC provider satisfaction survey results
20. MCC operational and departmental policies and procedures
21. Analysis of MCC communication to enrollees and providers outlining member rights and responsibilities
22. Verification of MCC commitment to improve patient safety
23. Annual comparative analysis of MCC compliance with EPSDT requirements to include:
    a. Identification of best practices
    b. Evidence of enrollee and provider educational outreach by individual MCC
24. Evaluation of the timeliness and appropriateness of triage and referrals for behavioral health to include a review of written protocols.

3. Add the following to A.1.2.4.C.:

    28. Review and assess MCC compliance with the current IEP process.

4. Delete A.2.2.4.H in its entirety.

5. Delete A.1.2.4.N. in its entirety and replace with the following:

    A.1.2.4.N. Hosting quarterly meetings with MCCs and interrelated oversight agencies to inform them of pertinent/current issues. A list of dates and places for the quarterly meetings for the upcoming year shall be sent to TennCare no later than January 15th. In conjunction with TennCare, efforts shall be made to secure speakers to discuss pertinent topics and continuing education credits shall be offered for physicians and

registered nurses for at least one meeting a year.

6. Delete the first paragraph of A.1.2.5 and replace with the following:

   The Contractor shall prepare for each key activity a draft report, an executive summary, and a full written report detailing findings and recommendations for each MCC. Reports shall identify best practices and opportunities for improvement, as well as recommendations specific to each MCC program. Unless otherwise specified all reports shall be submitted to the State in both hard copy and electronic format. The number of hard copy reports and the electronic format shall be determined for each report and shall be mutually agreed upon by the Contractor and the State.

7. Delete A.1.2.5.E. in its entirety.

8. Add the following language to Section A.1.2.5:

   A.1.2.5.N. A detailed report of activities performed during each month, in a format designated by TennCare, shall be submitted to TennCare along with each monthly invoice.

9. Add the following to Section A.1.2.8:

   A.1.2.8.D. The Contractor shall identify and ensure that key personnel designated to work on EQR functions, including the Project Director, the Clinical Specialist for EPSDT, two technical writers, an Epidemiologist, an analyst, and a database administrator, shall work exclusively with the Office of the Chief Medical Officer at TennCare and on no other TennCare project.

The other terms and conditions of this Contract not amended hereby shall remain in full force and effect.