AMENDED AND RESTATED CONTRACTOR RISK AGREEMENT BETWEEN

THE STATE OF TENNESSEE,
d.b.a. TENNCARE

AND

(NAME OF CONTRACTOR)
(d.b.a. Trade-name)

CONTRACT NUMBER: FA_____

July 1, 2001
Blended Document – Includes General Amendments 1 through 12

TABLE OF CONTENTS

SECTION 1 - GENERAL PROVISIONS 2

1-1. NOTICE AND AGREEMENT 2
1-2. ENTIRE AGREEMENT 2
1-3. DEFINITIONS 3
1-4. APPLICABILITY OF THIS AGREEMENT 15
1-5. FRAUD AND ABUSE 15
1-5.a. Reporting and Investigating Suspected Fraud and Abuse 15
1-5. b. Fraud and Abuse Compliance Plan 16
1-6. PERSONS ELIGIBLE FOR ENROLLMENT 18
1-7. PREVIOUS CONTRACT REQUIREMENTS 18

SECTION 2 - CONTRACTOR RESPONSIBILITIES 19

2-1. GENERAL 19
2-2. CONTRACTOR QUALIFICATIONS 19
2-3. BENEFITS/SERVICE REQUIREMENTS AND LIMITATIONS 23
2-3.a. Covered Benefits 23
2-3.a.1. TennCare Covered Benefits Chart 23
2-3.a.1.(a) TennCare Benefits, prior to July 1, 2006: 23
2-3.a.1(b) TennCare Benefits, effective July 1, 2006: 28
2-3.a.2. Soft Limits/Service Thresholds for Certain Physical Health Services 35
2-3.a.3. Medical Necessity Determination 35
2-3.a.4. Preventive Services 36
2-3.b. Availability and Accessibility of Services 38
2-3.b.1. Primary Care Providers (PCPs) 38
2-3.b.3. Availability and Accessibility of Emergency Medical Services 41
2-3.c. Specialized Services 41
2-3.c.1. Children At Risk Or In DCS Custody 41
2-3.c.2. Mental Health/Substance Abuse Services 44
2-3.c.3 Coordination of Dental Benefits 49
2-3.c.4 Coordination of MCO and PBM Benefits 54
2-3.c.5 Coordination with the Department of Education 54
2-3.d. Prior Authorization for Covered Services 55
2-3.d.1. General Rule 55
2-3.d.2. At time of Enrollment 55
2-3.d.3. Prenatal Care 56
2-3.d.4. Notice of Adverse Action Regarding Prior Authorization Requests 56
2-3.d.5 Appeals related to Prior Authorization/Medical Necessity Denials 56
2-3.e. Additional Services and Incentives 57
2-3.f. Institutional Services and Alternatives to Institutional Services 57
2-3.g. Coordination with Medicare 57
2-3.h. Use of Cost-Effective Alternative Services 58
2-3.i. Cost Sharing for Services 58
2-3.j. Primary Care Providers/Case Management/Continuity of Care 60
2-3.j.1. Primary Care Providers 60
2-3.j.2. Management of Medical Care and Coordination of Care 61
2-3.j.3. Referrals and Exemptions 63
2-3.j.4. Abusive Utilizers of Pharmacy Services 64
2-3.j.5. Network Notice Requirements 64
2-3.j.5 (a) Enrollee Notification – Change in PCP 64
2-3.j.5 (b) Enrollee Notification – Provider Termination 64
2-3.j.5.(c) Enrollee Notification –Network Deficiency 65
2-3.j.5.(d) TENNCARE Notification – Provider Termination 65
2-3.k. Out of Area or Out of Plan Use 66
2-3.k.1. Emergency Medical Services obtained from Out of Plan Providers 66
2-3.k.2. MCO Assignment Unknown – Services Obtained from Out-of-Plan Provider 68
2-3.k.3. Medically Necessary Services obtained from Out of Plan Providers/Referred by Contract Provider 68
2-3.k.4. Medically Necessary Services obtained from Out-of-Plan Providers/ Non-Referred 68

2-3.k.5. Services Ordered by Medicare Providers for Dual Eligibles 69
2-3.k.6. Credentialing of Non-Contract Providers 69
2-3.l. Advance Directives 69
2-3.m. Compliance with the Clinical Laboratory Improvement Act (CLIA) of 1988. 69
2-3.n. Safety Net Providers 70
2-3.n.1. Federally Qualified Health Centers (FQHCs) 70
2-3.n.2. Local Health Departments 70
2-3.o. Coverage of Sterilizations, Abortions and Hysterectomies 71
2-3.o.1. Sterilizations 71
2-3.o.2. Abortions 72
2-3.o.3. Hysterectomy 72
2-3.p. Coverage of Organ and Tissue Transplants 72
2-3.q. Use of a Drug Formulary 73
2-3.r. Prenatal Care 75
2-3.s. Utilization Management 76
2-3.t. Availability and Accessibility of Emergency Medical Services 84
2-3.u. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements 85
2-3.v Notice of Action to Enrollees 97
2-3.w Compliance with Health Insurance Portability and Accountability Act (HIPAA) Requirements 97
2-4. SERVICES NOT COVERED 101
2-5. MARKETING AND ENROLLEE MATERIAL 101
2-5.a. Marketing 101
2-5.b. Enrollee Materials 101
2-5.b.1. Member Handbooks 101
2-5.b.2. Quarterly Newsletter 104
2-5.b.3. Identification Card 105
2-5.b.4. Provider Directory 106
2-5.c. Permissible Marketing and/or Communication Activities 106
2-5.d. Prohibited Marketing and/or Communication Activities 106
2-5.e. Prior Approval Process for All Marketing Activities/Materials and Enrollee Materials 107
2-5.f. Written Material Guidelines 108
2-5.g. Failure to Comply with Marketing and Enrollee Material Requirements 109
2-6. ENROLLMENT 109
2-6.a. Enrollment Guidelines 109
2-6.b. Enrollment Procedures 113
2-7. DISENROLLMENT 114
2-7.a. Unacceptable Reasons for Disenrollment 114
2-7.b. CONTRACTOR's Responsibility for Disenrollments 115
2-8. COMPLAINTS AND APPEALS 115
2-8.a. Appeals 115
2-9. ADMINISTRATION AND MANAGEMENT 117
2-9.a. General Requirements 117
2-9.b. Performance Standards 117
2-9.c. Staff Requirements 123
2-9.d. Licensure of Staff 126
2-9.e. Employment of Personnel 126
2-9.f. Subcontracts and Provider Agreements 127
2-9.g. Data that must be Certified 127
2-9.h. CONTRACTOR's Policies and Procedures 127
2-9.i. Medical Records Requirements 128
2-9.j. Quality Monitoring/Quality Improvement (QM/QI) Program 129
2-9.j.1. QM/QI Meeting Requirements 129
2-9.j.2. Clinical and Service Quality Improvement/Performance Improvement Activities 129
2-9.j.3. Clinical Practice Guidelines 130
2-9.j.4. Performance Indicators 130
2-9.j.5. EPSDT (TENNderCare) 130
2-9.j.6. Credentialing and Recredentialing 131
2-9.j.7 NCQA Accreditation 131
2-9.k. Financial Management 133
2-9.k.1. Fixed Administrative Fee Payments 133

2-9.k.2. Savings/Loss 133
2-9.k.3. Return of Funds 133
2-9.k.4. Financial Reserves 134
2-9.k.5. Interest 135
2-9.k.6. Third Party Resources (TPL) 135
2-9.l. Responding to Enrollee Complaints or Appeals 137
2-9.m. Claims Processing Requirements 137
2-9.m.1. Timeliness of Payments 137
2-9.m.2. Claims Payment Accuracy – Minimum Audit Procedures 138
2-9.m.3. Electronic Billing 138
2-9.m.4. Standard Forms and Billing Instructions 139
2-9.m.5. Edits 139
2-9.m.6. Timely Filing 139
2-9.m.7. HIPAA Compliance 139
2-9.m.8. Eligibility for Services 139
2-9.m.9. EPSDT (TENNderCare) Reimbursement 140
2-9.m.10 Explanation of Benefits (EOBs) 140
2-9.m.11. Remittance Advice to Providers 140
2-9.m.12. Encounter Data 140
2-9.m.13. Overpayment due to CONTRACTOR Error 141
2-9.m.14. Overpayment due to Provider Error 141
2-9.m.15. Liquidated Damages/Sanctions 141
2-9.n. Network Management 141
2-9.o Business Continuity and Disaster Recovery (BC-DR) Plan 144
2-10. REPORTING REQUIREMENTS 145
2-10.a. General Requirements 145
2-10.b. Reporting Enrollee Information 145
2-10.b.1. Enrollee Information, Weekly Reporting 145
2-10.b.2. Enrollee Verification Information, On Request 146
2-10.b.3. Eligibility and Premium Reconciliation 146
2-10.b.4. Enrollee Cost Sharing 147
2-10.b.5. Enrollee EOB Reporting 147
2-10.c. Provider Enrollment Reporting 147
2-10.c.1. Monthly Provider Enrollment File 147
2-10.c.2. Essential Hospital Services Chart 147
2-10.c.3. Specialty Physician Services Chart 148
2-10.d. Reporting of Other Insurance 148
2-10.e. Medical Services Payment Reporting 148
2-10.e.1 Individual Encounter Reporting 148
2-10.e.2. TPL Reporting 148
2-10.e.3. Reporting Provider Payment Issues 148
2-10.f. Monthly Activity Reporting 149
2-10.g. Network Clearing House Reporting 150
2-10.g.1. Eligibility Web Site 151
2-10.g.2. Claims Payment Status Web Site 151
2-10.h. Financial Reporting 151
2-10.h.1. Financial Plan and Projection of Operating Results 151
2-10.h.2. Annual Report 152
2-10.h.3. Quarterly Reports 152
2-10.h.4. Audit of Business Transactions 152
2-10.i. Reporting CONTRACTOR Administrative and Staffing Information 153
2-10.i.1. Non-discrimination Compliance 153
2-10.i.2. Contact Persons 153
2-10.i.3. Board of Directors 153
2-10.j. Medical Services Monitoring Report 153
2-10.k. FQHC Reporting 154
2-10.l. Business Continuity and Disaster Recovery Reports 154
2-10.m. Quality Improvement Reports 154
2-10.m.1. Annual Review and Approval of the Quality Improvement Program 154
2-10.m.2. Quarterly Quality Improvement Activities Update 154
2-10.m.3. PCP Assignment 154
2-10.m.4. Quality Improvement Reporting 154

2-10.m.5 EPSDT Reporting 155
2-10.m.6 NCQA Accreditation Status Update 155
2-10.m.7. Disease Management Evaluation 155
2-10.m.8. Outlier Reporting 155
2-10.m.9. Case Management Reporting 156
2-10.n Cost and Utilization Summaries 156
2-10.n.1 Prescription Drug Summary 156
2-10.n.2 Top 25 Providers by Amount Paid 156
2-10.n.3 Top 25 Inpatient Diagnoses by Frequency and Amount Paid 157
2-10.n.4 Top 25 Outpatient Diagnoses by Frequency and Amount Paid 157
2-10.n.5 Top 10 Inpatient Surgical / Maternity Procedures by Frequency and Amount Paid 158
2-10.n.6 Top 10 Outpatient Surgical /Maternity Procedures by Frequency and Amount Paid 158
2-10.n.7 High-Cost Claimants 158
2-10.o. Cost and Utilization Reports 159
2-10.p. Network Management 159
2-10.p.1 PCP Visits 159
2-10.p.2 Out-of-Network Utilization 159
2-10.p.3 Emergency Room Utilization 159
2-10.p.4 Specialty Utilization 160
2-10.p.5 24/7 Nurse Triage Call Line 160
2-10.q HIPAA Reporting 160
2-10.r. Prior Authorization Reporting 160
2-10.s Subcontracted Claims Processing Report 162
2-11. ACCOUNTING REQUIREMENTS 162
2-12. AVAILABILITY OF RECORDS 162
2-13. AUDIT REQUIREMENTS 164
2-14. INDEPENDENT REVIEW OF THE CONTRACTOR 164
2-15. ACCESSIBILITY FOR MONITORING 164
2-16. CHANGES RESULTING FROM MONITORING AND AUDIT 165
2-17. SUBCONTRACTS 165
2-18. PROVIDER AGREEMENTS 168
2-19. FIDELITY BONDS AND INSOLVENCY PROTECTION 173
2-20. INSURANCE 174
2-21. OWNERSHIP AND FINANCIAL DISCLOSURE 174
2-22. AUTHORIZED COMMUNITY SERVICES AREA(S) 175
2-22.a. CONTRACTOR's Authorized Service Areas 176
2-22.b. Expansion of Service Area 176
2-22.c. Termination of Community Service Area 177
2-23. CONTRACTOR APPEAL RIGHTS 178
2-24. NON-DISCRIMINATION COMPLIANCE 178
2-25. NOTICE OF LEGAL ACTION 180
2-26. PROHIBITION OF ILLEGAL IMMIGRANTS. 180

SECTION 3 - TENNCARE RESPONSIBILITIES 182

3-1. GENERAL RESPONSIBILITIES 182
3-2. ELIGIBILITY DETERMINATION 182
3-3. APPROVAL PROCESS 182
3-4. INTERPRETATIONS 183
3-5. FACILITY INSPECTION 183
3-6. MONITORING 183
3-7. ENROLLMENT, DISENROLLMENT AND ELIGIBILITY VERIFICATION 184
3-8. APPEAL 184
3-9. TECHNICAL ASSISTANCE 185
3-10. PAYMENTS TO THE CONTRACTOR 185
3-10.a. The Capitation Rate 185
3-10.b. Annual Actuarial Study 185
3-10.c. Payment of the Capitation Rate 185
3-10.d. Withhold of the Capitation Rate 188
3-10.e. Financial Accountability and Risk Arrangements 189
3-10.e.1. Medical Loss Ratio 189

3-10.e.2. Profit/Loss Risk Banding 190
3-10.e.3. Provider Reimbursement 193
3-10.f. Effect of Disenrollment on Capitation Payments 194
3-10.g. Left Blank Intentionally 194
3-10.h. Stabilization Period Payment Terms and Conditions 194
3-10.h.1. Fixed Administrative Fee 195
3-10.h.2. Payment for Covered Services 195
3-10.h.2(a) Payment Requirements 195
3.10.h.2(b) Provider Payment Process 195
3-10.h.2(c) 1099 Preparation 196
3-10.h.2(d) Interest 196
3-10.h.2(e) Pharmacy Rebates 196
3-10.h.2(f) Third Party Liability Resources 196
3-10.h.2(g) Reinsurance recoveries 197
3-10.h.2(h) HMO Payment Tax 197
3-10.h.2(i) Service Dates 197
3-10.h.2(j) Covered Services 197
3-10.h.2(k) Cost-Sharing 198
3-10.h.3. Variable Administrative Fee Payment 198
3-10.h.3(a) Variable Administrative Fee Payment for Fiscal Year 2005 202
3-10.h.4. Medical Fund Target 203
3-10.h.5. Disallowances 204
3-10.h.6. Provider Reimbursement 204
3-10.h.7. Effect of Disenrollment on the Fixed Administrative Fee Payments 204
3-10.i. Shared Risk Terms and Conditions 205
3-10.i.1. Administrative Fee 206
3-10.i.2 Medical Services Budget Target 206
3-10.i.3. Risk Component 207
3-10.i.3(a) Medical Services Budget Target Initiative 207
3-10.i.3(b) Pharmacy Generic Use: 207
3-10.i.3(c) Completion of Major Milestones for NCQA: 208
3-10.i.3(d) Increase EPSDT Compliance 209
3-10.i.3(e) Non-Emergency ER Visits per 1000: 209
3-10.i.3(f) Inpatient Admissions per 1000: 210
3-10.i.3(g) Inpatient Days Per 1000 210
3-10.i.4. Performance Bonuses 211
3-10.i.5 Risk and Bonus Payout Reconciliation 212
3-10.i.6 Payment for Covered Services 212
3-10.i.6(a) Payment Requirements 213
3.10.i.6(b) Provider Payment Process 213
3-10.i.6(c) 1099 Preparation 214
3-10.i.6(d) Interest 214
3-10.i.6(e) Third Party Liability (TPL) Resources 214
3-10.i.6(f) Reinsurance recoveries 214
3-10.i.6(g) HMO Payment Tax 214
3-10.i.6(h) Service Dates 215
3-10.i.6(i) Covered Services 215
3-10.i.6(j) Cost-Sharing 215
3-10.i.7. Disallowances 216
3-10.i.8. Provider Reimbursement 216
3-10.i.9. Effect of Disenrollment on the Fixed Administrative Fee Payments 217
3-10.i.10. Additional Payment for Specified Achievement Level of Initial NCQA Accreditation 217
3-10.i.11. Pay-for-Performance Quality Incentive 218
3-11. SERVICES PROVIDED BY TENNCARE 219
3-12. PROGRAM INFORMATION 220
3-13 PHARMACY ENCOUNTER DATA 220

SECTION 4 - TERMS AND CONDITIONS 221

4-1. APPLICABLE LAWS AND REGULATIONS 221
4-2. TERMINATION 222
4-2.a. Termination Under Mutual Agreement 223
4-2.b. Termination by TENNCARE for Cause 223
4-2.c. Termination for Unavailability of Funds 224

4-2.d. Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy *224*
4-2.e. Termination by TENNCARE for Convenience *225*
4-2.f. Notice of Non-renewal by the CONTRACTOR or TENNCARE *225*
4-2.g. Termination Procedures *225*
4-3. ERRORS 227
4-4. USE OF DATA 228
4-5. WAIVER 228
4-6. AGREEMENT VARIATION 228
4-7. CONFLICT OF INTEREST 228
4-8. FAILURE TO MEET AGREEMENT REQUIREMENTS 229
4-8.a. Intermediate Sanctions *229*
4-8.b. Liquidated Damages *231*
4-8.b.1. Reports and Deliverables 231
4-8.b.2. Program Issues 231
4-8.b.3. Payment of Liquidated Damages 239
4-8.b.4. Waiver of Liquidated Damages 239
4-8.c. Claims Processing Failure *240*
4-8.d. Failure to Manage Medical Costs *240*
4-8.e. Sanctions by CMS *241*
4-8.f. Temporary Management *241*
4-9. RENEGOTIATION PROCEDURES 241
4-10. TITLES 241
4-11. OFFER OF GRATUITIES 241
4-12. LOBBYING 241
4-13. INSPECTION OF WORK PERFORMED 242
4-14. ATTORNEY'S FEES 242
4-15. COURT OF JURISDICTION OR VENUE 242
4-16. ASSIGNMENT 242
4-17. INDEPENDENT CONTRACTOR 242
4-18. FORCE MAJEURE 242
4-19. DISPUTES 243
4-20. INDEMNIFICATION 243
4-21. NON-DISCRIMINATION 243
4-22. CONFIDENTIALITY OF INFORMATION 244
4-23. RATE ADJUSTMENT 244
4-24. ACTIONS TAKEN BY THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE 244
4-25. EFFECT OF THE FEDERAL WAIVER ON THIS AGREEMENT 244
4-26. TENNCARE FINANCIAL RESPONSIBILITY 245
4-27. EXIGENCY EXTENSION 245
4-28. TERM OF THE AGREEMENT 245

ATTACHMENTS 215

ATTACHMENT I - DELIVERABLE REQUIREMENTS 216
ATTACHMENT II – ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE 224
ATTACHMENT III - TERMS AND CONDITIONS FOR ACCESS 226
ATTACHMENT IV - SPECIALTY NETWORK STANDARDS 230
ATTACHMENT V - INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT FORM 232
ATTACHMENT VI - INSTRUCTIONS FOR COMPLETING "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" 238
ATTACHMENT VII - INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM 243
ATTACHMENT VIII - EPSDT SCREENING GUIDELINES 249
ATTACHMENT IX - FORMS FOR REPORTING FRAUD AND ABUSE 276
ATTACHMENT X - CAPITATION RATES 279
ATTACHMENT XI - COST SHARING SCHEDULES 287
ATTACHMENT XII - REPORTING REQUIREMENTS 290
ATTACHMENT XII, EXHIBIT A - REPORTING ENROLLEE INFORMATION/ REQUIRED DATA ELEMENTS *291*
ATTACHMENT XII, EXHIBIT B – ENROLLEE VERIFICATION REPORTING/REQUIRED DATA ELEMENTS *293*

ATTACHMENT XII, EXHIBIT C - PROVIDER ENROLLMENT REPORTING/REQUIRED DATA ELEMENTS *295*
ATTACHMENT XII, EXHIBIT D – ESSENTIAL HOSPITAL SERVICES CHART *298*
ATTACHMENT XII, EXHIBIT E – LEFT BLANK INTENTIONALLY *301*
ATTACHMENT XII, EXHIBIT F - REPORTING OTHER INSURANCE/REQUIRED DATA ELEMENTS *302*
ATTACHMENT XII, EXHIBIT G - INDIVIDUAL ENCOUNTER REPORTING/REQUIRED DATA ELEMENTS *304*
ATTACHMENT XII, EXHIBIT H –QUALITY IMPROVEMENT REPORTS *306*
ATTACHMENT XII, EXHIBIT I – MONTHLY ACTIVITY REPORT *316*
ATTACHMENT XII, EXHIBIT J – MEDICAL SERVICES MONITORING REPORT *320*
ATTACHMENT XII, EXHIBIT K – FQHC REPORTING *327*
ATTACHMENT XII, EXHIBIT L – COST AND UTILIZATION REPORTING *329*
ATTACHMENT XII, EXHIBIT M – ELIGIBILITY AND PREMIUM RECONCILIATION REPORTING *338*
ATTACHMENT XIII - LEFT BLANK INTENTIONALLY 343
ATTACHMENT XIV – PREVIOUS CONTRACT REQUIREMENTS 344
ATTACHMENT XV - RISK BANDING MANUAL 347

AMENDED AND RESTATED CONTRACTOR RISK AGREEMENT

BETWEEN

THE STATE OF TENNESSEE, d.b.a. TENNCARE

AND

(Name of a CONTRACTOR, d.b.a.)
(Trade-name)

This Agreement is entered into by and between THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" and (name of a CONTRACTOR), hereinafter referred to as "the CONTRACTOR".

WHEREAS, the purpose of this Agreement is to assure Tennesseans of quality health care services while controlling the costs of such health care services;

WHEREAS, under the previous health care systems in Tennessee, a significant number of working Tennesseans are without access to health insurance;

WHEREAS, the previous Medicaid Program was characterized by inflexibility, encouragement of dependency on welfare and unmanageable growth;

WHEREAS, consistent with waivers granted by the Centers for Medicare and 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 medical services to persons who are or would have been Medicaid eligible under the Medicaid program as it was administered during state fiscal year 1992-93 and non-Medicaid eligible Tennesseans who are uninsured as described in TennCare Rules and Regulations or who are uninsurable and who are enrolled in the TennCare managed care program;

WHEREAS, the Tennessee Department of Finance and Administration is the State Agency responsible for administration of the managed care program in Tennessee and is authorized to contract with MCOs for the purpose of providing the services specified herein for the benefit of persons who are or would have been Medicaid eligible under the Medicaid program as it was administered during state fiscal year 1992-93 and for the benefit to other Tennesseans who are eligible for and are enrolled in the TennCare system; and

WHEREAS, the CONTRACTOR is a corporation which has qualified as a Health Maintenance Organization as described in the Code of Federal Regulations 42 CFR Part 434 or complies with Tennessee Code Annotated Section 56-32-201 (et. Seq.), is licensed to operate as a health maintenance organization in the State of Tennessee, is capable of providing or arranging for health care services provided to covered persons for whom it has received prepayment and 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 - GENERAL PROVISIONS

1-1. Notice and Agreement

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, 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 Road
Nashville, Tennessee 37243

If to the CONTRACTOR:

1-2. Entire Agreement

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 except to the extent that the provisions of Section 1-7 of this Agreement apply. Correspondence and memorandums of understanding do not constitute part of this Agreement.

In the event of a conflict of language between the Agreement and any Amendments, the provisions of the Amendments shall govern. All applicable laws, regulations, court orders and policies (hereinafter referred to as Applicable Requirements), including those described in Section 4-1 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, provided, however, that nothing contained herein shall prejudice, restrict or otherwise limit the CONTRACTOR's right to maintain existing actions or initiate future actions 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.

1-3. Definitions

The terms used in this Agreement shall be given the meaning used in the Rules and Regulations of the Bureau of TennCare. 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 the Definitions, Addendum, Attachments, and other Sections of this Agreement, the language in Sections 1 through 4 of this Agreement shall govern.

1. 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:

   - Satisfying Contractor Qualifications specified in Section 2-2;
   - Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2-3.b, Attachment III and Attachment IV and requirements for the delivery of Specialized Services specified in Section 2-3.c;
   - Determination of recoveries from Third Party Liability resources in accordance with Section 2-9.k.6 and 3-10.h.2(f);
   - Claims Processing in accordance with Section 2-9.m;
   - Administration of this Agreement in accordance with Medical Management Policies and Procedures including, but not limited to: Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2-3.d; Referral and Exemption requirements established in accordance with Section 2-3.j.3; Out of Area or Out of Plan Use policies and procedures established in accordance with Section 2-3.k; Transplant policies and procedures established in accordance with Section 2-3.p; Prescription Drug Formulary established in accordance with Section 2-3.q; Prenatal Care policies and procedures established in accordance with Section 2-3.r; Quality Monitoring/Quality Improvement Program established in accordance with Section 2-9.j; Management of Medical Care and Coordination of Care policies and procedures established in accordance with Section 2-3.j, with the exception of Medical Case Management;
   - Enrollment and Disenrollment in accordance with Sections 2-6 and 2-7;
   - Appeals processing and resolution in accordance with Section 2-8;
   - Quality Assurance and Improvement activities as specified in Section 2-9.j and Attachment II;
   - Production and submission of required reports as specified in Section 2-10;
   - Production and distribution of Marketing and Enrollee Materials as specified in Section 2-5; and
   - All other Administration and Management responsibilities as specified in Sections 2-11 through 2-24 and other activities required to be conducted in Attachment I, V, VI, VII, XI, XII, XIII.

   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, marketing) are considered to be an "administrative cost" with the exception of the cost of recovery of third party liability (TPL), when approved by TENNCARE.

2. Administrative Rate - The amount established by TENNCARE pursuant to the methodology described in Section 3-10.h.1 of this Agreement.

3. 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.

4. 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 1200-13-12-.11, 1200-13-13-.11, 1200-13-14-.11 and any and all applicable court orders. Complaint shall mean an enrollee'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.

5. Baseline Assessment Tool (BAT) – Tool provided by the National Committee for Quality Assurance to complete and forward to the approved Health Employer Data and Information Set auditing firm as the initial step in the HEDIS audit.

6. Behavioral Health Services – Generally recognized and accepted mental health and substance abuse services.

7. Benefits - A schedule of health care services to be delivered to enrollees covered in the CONTRACTOR's plan developed pursuant to Section 2-3 of this Agreement.

8. Best Practice Guidelines—Guidelines for provision of health and behavioral health services to children in state custody.

9. Best Practice Network (BPN)—A group of Best Practice Providers.

10. Best Practice Provider (BPP)—A provider (primary care, behavioral health, or dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in state custody, in accordance with the Remedial Plan and statewide Best Practice Guidelines, and who has agreed to be in the MCO network.

11. Behavioral Health Organization (BHO) - An entity which organizes and assures the delivery of mental health and substance abuse services.

12. Capitation Payment - The fee which is paid by TENNCARE to a CONTRACTOR for each enrollee covered under a plan for the administration of this Agreement and the payment and provision of medical services, whether or not the enrollee utilizes services during the payment period. The CONTRACTOR is at financial risk as specified in this Agreement for the payment of services incurred in excess of the amount of the capitation payment.

13. Capitation Rate - The amount established by TENNCARE pursuant to the methodology described in Section 3-10.c of this Agreement.

14. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.

15. Center of Excellence for Children in or at Risk of State Custody - Tertiary care academic medicine center designated by the state as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in or at risk of state custody.

16. Center of Excellence 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 eligibles with HIV disease.

17. CFR - Code of Federal Regulations.

18. Children At Risk of State Custody - Children who are determined to belong in one of the following two groups:

    a. Children at imminent risk of entering custody - Children who are at risk of entering state custody as identified pursuant to TCA 37-5-103(10).

    b. Children at serious risk of entering custody - Children whom DCS has identified as a result of a CPS referral; or children whose parents or guardians are considering voluntary surrender (who come to the attention of DCS); and who are highly likely to come into custody as a result of being unable to access behavioral health services.

19. Children with Special Health Care Needs Steering Panel (CSHCN Steering Panel) - An entity designated by the state to advise concerning the development of a health service system for children in state custody, in accordance with the Remedial Plan and the EPSDT Consent Decree.

20. Clarification –A revision that is not a change or amendment to the Agreement but is only a revision in language to more accurately reflect the existing agreement between the parties. Such clarification is a housekeeping item only, and as such, bears an effective date of the Agreement.

21. Clean claim - A claim received by the MCO for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the MCO.

22. Clinical Practice Guidelines – Systematically developed tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Such guidelines are usually evidence-based. **See practice guidelines.**

23. CMS - Centers for Medicare & Medicaid Services [formerly Health Care Financing Administration (HCFA)].

24. Community Service Area - one (1) or more counties in a defined geographical area in which the CONTRACTOR is authorized to enroll and serve TennCare members in exchange for a monthly capitation fee.

    The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy
Shelby CSA	-	Shelby County

Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson

25. Complaint – The process to resolve an enrollee's right to contest any 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.

26. Consumer Assessment of Health Plans Study (CAHPS) – A set of standardized surveys that measure patient satisfaction with experience of care. CAHPS is sponsored by the Agency for Health Care Quality.

27. Covered Service - See Benefits.

28. Dental Benefits Manager (DBM) - An entity responsible for the provision and administration of dental services, as defined by TENNCARE.

29. 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.

30. DCS Custody Children - Children who have been identified by DCS as belonging in one of the following groups:

    a. Children in the custody of DCS—Children in the legal and physical custody of DCS whose living arrangement is provided by DCS.

    b. Children in the legal, but not physical, custody of DCS—Children who are in DCS's legal custody but who reside with parents or guardians or other caretakers.

31. DHHS - United States Department of Health and Human Services.

32. Disenrollment - The discontinuance of a member's entitlement to receive covered services under the terms of this Agreement, and deletion from the approved list of members furnished by TENNCARE to the CONTRACTOR.

33. Electronic Protected Health Information (EPHI) – A Protected Health Information that is transmitted by or maintained in electronic media (45 C.F.R. Section 160.103).

34. Eligible Person - Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare Program.

35. Emergency Medical Services (or Emergency Services) –Covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard, including services for which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; and emergency ambulance transport.

36. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

37. Enrollee - Any person who has enrolled in the CONTRACTOR's plan in accordance with the provisions of this Agreement. (See Member, also).

38. Enrollee Month - A month of health care coverage for a TennCare eligible enrolled in an MCO plan.

39. Enrollees with Special Health Care Needs – For purposes of requirements in Sections 2-3.j.2(l) and (m) of this Agreement, enrollees with special health care needs shall refer to enrollees identified through the Department of Children's Services (DCS).

40. Enrollment - The process by which a person becomes a member of the CONTRACTOR's plan.

41. Essential Hospital Services – Hospital services to which it is essential for an MCO to provide access. Essential Hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

42. Executive Oversight Committee - The committee designated by the state to have primary oversight responsibility for the implementation of a health service system for children in state custody, in accordance with the Remedial Plan and the EPSDT Consent Decree.

43. 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.

44. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment for defined services.

45. Fixed Administrative Fee Payment - The fee which is paid by TENNCARE to a CONTRACTOR for each enrollee covered under a plan for the administration of this Agreement and arrangement of medical services, whether or not the enrollee utilizes services during the payment period.

46. FTE - Full time equivalent position.

47. Grand Region – A defined geographical region that include specified Community Service Areas in which a CONTRACTOR is authorized to enroll and serve TennCare members in exchange for a monthly capitation fee. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

East Grand Region	Middle Grand Region	West Grand Region
First Tennessee	Upper Cumberland	Northwest
East Tennessee	Mid Cumberland	Southwest
Knox	Davidson	Shelby
Southeast Tennessee	South Central	
Hamilton		

48. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32.

49. Health Plan Employer Data and Information Set (HEDIS) – The most widely used set of performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is developed and maintained by the National Committee for Quality Assurance.

50. Hospice - Services as described in Medicaid rule 1200-13-10 and the Code of Federal Regulations 42 CFR Part 418 which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

51. Implementation Team - A team of medical professionals under the direction of the Commissioner of Health who are charged with staffing the Executive Oversight Committee and overseeing the operational details of the Remedial Plan. The Implementation Team can determine if services which have been ordered for children at risk of custody and denied by the MCO are to be implemented while awaiting the results of an appeal.

52. Intervention - An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

53. IRS - Drugs that are Identical, Related or Similar to LTE drugs.

54. 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).

55. LTE - Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

56. MCO and BHO Coordination Agreement – An agreement between the MCO and BHO that specifies roles and responsibilities of each organization designed to assure care coordination, case management and continuity of care.

57. Managed Care Organization ("MCO") - An HMO which participates in the TennCare program.

58. Marketing - Any activity conducted by or on behalf of the CONTRACTOR where information regarding the services offered by the CONTRACTOR is disseminated in order to persuade eligible persons to enroll or accept an application for enrollment in the CONTRACTOR's plan operated pursuant to this Agreement.

59. Market Area - One (1) or more community service areas in which the CONTRACTOR is authorized, by terms of this Agreement, to market eligible persons for enrollment in the CONTRACTOR's plan.

60. Medical Expenses (sometimes referred to as "Covered Services") - Consist of the following:

a. The cost of providing TennCare Program medical services to enrollees as identified below and pursuant to the following listed subsections of Section 2-3 of the CRA:

1. 2-3.a Covered Services
2. 2-3.c Specialized Services
3. 2-3.h Use of Cost Effective Alternative Services
4. 2-3.o Coverage of Sterilization's, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
5. 2-3.p Coverage of Organ and Tissue Transplants
6. all services related to hospice
7. capitated payment to licensed health care providers
8. medical services directed by TENNCARE or an Administrative Law Judge
9. net impact of reinsurance coverage purchased by the MCO

b. Preventive Services: In order for preventive services in Section 2-3 (including, but not limited to, health education, and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR's enrollees or targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.

c. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.

d. Medical Expenses do not include:

1. 2-4. Services Not Covered;
2. 2-3.f. Institutional Services and Alternatives to Institutional Services;
3. Services eligible for reimbursement by Medicare;
4. The activities described in or required to be conducted in Attachments I, II, III, IV, V, VI, VII, XI, XII, XIII (including, but not limited to, utilization management, utilization review activities) are administrative costs; and
5. The two percent HMO tax.

e. Medical expense will be net of any TPL recoveries or subrogation activities. If approved by TENNCARE, the TPL or subrogation recoveries may be net of administrative expenses incurred that are related to recovery activities.

e. Medical expense will be net of any pharmacy rebates.

f. This definition does not apply to NAIC filings.

61. Medical Fund Target – The funding level for covered services determined to be appropriate for the applicable population based on the health status of the population stated on a per member per month basis.

62. Medical Loss Ratio – The percentage of capitation payment received from TENNCARE that is paid for medical expenses (covered medical services).

63. Medical Management Polices and Procedures – All policies and procedures related to the coordination and provision of services including, but not limited to:

- Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2-3.d;
- Referral and Exemption Requirements established in accordance with Section 2-3.j.3;
- Out of Area or Out of Plan Use policies and procedures established in accordance with Section 2-3.k;
- Transplant policies and procedures established in accordance with Section 2-3.p;
- Prescription Drug Formulary established in accordance with Section 2-3.q;
- Prenatal Care policies and procedures established in accordance with Section 2-3.r;
- Quality Monitoring/Quality Improvement Program established in accordance with Section 2-9.j; and
- Management of Medical Care and Coordination of Care policies and procedures established in accordance with Section 2-3.j.

64. Medical Records - All medical 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 documentation in written or electronic format; and analyses of such information.

65. Medically Necessary – Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in regulations at 1200-13-16-.01, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in regulations at 1200-13-16-.01.

66. Member - A person who enrolls in the CONTRACTOR's plan under the provisions of this Agreement with TENNCARE. (See Enrollee, also).

67. NAIC – National Association of Insurance Commissioners.

68. 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. Useful information on NCQA may be accessed at the NCQA website: www.ncqa.org

69. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or under contract with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

70. Non-Risk – No chance of financial loss assumed by the CONTRACTOR when loss arises because the cost of providing TennCare covered services exceeds the medical fund target established by TENNCARE.

71. Office of Inspector General (OIG) - The Office of Inspector General 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 TennCare administratively, civilly or criminally.

72. Out-of-Plan Services - Services provided by a non-contract provider.

73. Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

74. Post-stabilization Care Services - Non-emergency services subsequent to an emergency that a treating physician views as medically necessary to maintain the stabilized condition after an emergency medical condition has been stabilized or to improve or resolve the enrollee's condition. An MCOs financial responsibility for post stabilization care services shall end when one of the following are met:
    1. A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
    2. A plan physician assumes responsibility for the enrollee's care through transfer;
    3. An MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
    4. The enrollee is discharged.

75. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.

76. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

77. Practice Guidelines – Systematically developed descriptive tools or standardized specifications for care to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. Practice guidelines may also be called **practice parameters, treatment protocols, clinical criteria, or clinical guidelines**.

78. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

79. Primary Treatment Center (PTC)—A center developed by DCS for the purpose of providing short-term evaluation and treatment to children who have just come into custody, children already in state custody, children who have been released from state custody and who have been recommitted, and children who are at imminent risk of entering custody.

80. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.

81. Privacy Rule - The standards for the Privacy of Individually Identifiable Health Information at 45 C.F.R., Part 160 and Part 164.

82. Program Integrity – The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.

83. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by TENNCARE which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the CONTRACTOR.

84. Provider Agreement - An agreement between an MCO and a provider or an MCO's subcontractor and a provider of health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's members.

85. 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.

86. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge.

87. Remedial Plan for Children in Custody—The Agreed Order entered into by the state to insure the proper coordination and delivery of health services for children in custody, pursuant to the EPSDT mandate of the Medicaid Act and in accordance with the EPSDT Consent Decree.

88. Risk - Under a capitation payment methodology, risk shall mean the CONTRACTOR is responsible for all costs associated with providing required services. TENNCARE is only responsible for provision of capitation payment. Under an administrative fee methodology, risk shall mean a chance of loss assumed by the CONTRACTOR of a portion of the CONTRACTOR's administrative fee for failure to meet specific performance measures or medical cost targets.

89. Risk Reserve - An allocation of liquid assets or cash made by the CONTRACTOR pursuant to the requirements set forth in this Agreement which is designed to meet the risk assumed by the CONTRACTOR under this Agreement.

90. Routine Care – Non urgent medical care such as screenings, immunizations, or health assessments.

91. Savings - Residual monies remaining after the costs that the CONTRACTOR is responsible for as described in this Agreement are deducted from fees paid by TENNCARE.

92. 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.

93. Security Rule – The Security Standards for the Protection of Electronic Health Information at 45 C.F.R., Part 160 and Part 164.

94. Service Location - Any location at which an enrollee obtains any health care service covered by the CONTRACTOR pursuant to the terms of this Agreement.

95. Service Site - The locations designated by the CONTRACTOR at which members shall receive primary care provider and preventive services.

96. Services - The benefits described in Section 2-3 of this Agreement.

97. Shall - Indicates a mandatory requirement or a condition to be met.

98. Specialty Services – Includes Essential Hospital Services, services provided by a Center of Excellence, and specialty physician services.

99. Stabilization Period – The period of time during which all TENNCARE MCOs that execute General Amendment 2 to the CRA will temporarily operate under a non-risk agreement, from July 1 2002 through June 30, 2005, in order to allow MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist TENNCARE in restructuring the program design to better serve Tennesseans adequately and responsibly.

100. State - The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Department of Finance and Administration, the Office of Inspector General, the Department of Mental Retardation, the Bureau of TennCare, the Medicaid Fraud Control Unit, the Department of Mental Health and Developmental Disabilities, the Department of Children's Services, the Department of Health, the TennCare Division within the Department of Commerce and Insurance and the Office of the Attorney General.

101. 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, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the TENNCARE/MCO 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 2-3.a of the TENNCARE/MCO Agreement shall be considered Provider Agreements and governed by Section 2-18 of this Agreement.

102. 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.

103. TennCare - 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.

104. 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 the Medicaid/TennCare Rules and Regulations.

105. TENNCARE Representatives - The State of Tennessee and 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, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance, the Office of Inspector General and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

106. 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 beginning on July 1, 2002, and as amended by CMS on March 24, 2005 and the TennCare Rules and Regulations.

107. 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.

108. 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 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.

109. 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 medical care of the enrollee.

110. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party.

111. Urgent Care – Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

112. Variable Administrative Fee Payment – The administrative fee that is paid retrospectively by TENNCARE to a CONTRACTOR that successfully demonstrates achievement of specific performance levels identified by TENNCARE.

113. 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.

1-4. Applicability of this Agreement

All terms, conditions, and policies stated herein apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the CONTRACTOR. TennCare enrollees are the intended third party beneficiaries of contracts between the state and managed care organizations and of any subcontracts or provider agreements entered into by managed care organizations 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 the Bureau of TENNCARE or the State of Tennessee by enrollees beyond any that may exist under state or federal law.

1-5. Fraud and Abuse

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 State Medicaid program (TennCare).

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

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. Failure to comply with the fraud and abuse requirements set forth in this Agreement may result in liquidated damages as described in Section 4-8 of this Agreement.

1-5.a. Reporting and Investigating Suspected Fraud and Abuse

1-5.a.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 provisions of Tennessee Code Annotated Sections 71-5-2601 and 71-5-2603 in performance of its' obligations under this Agreement.

i. Fraud and abuse in the administration of the program. Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG.

ii. Provider fraud and abuse. All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU.

iii. Enrollee fraud and abuse. All confirmed or suspected enrollee fraud or abuse shall be reported immediately to OIG.

1-5.a.2. CONTRACTOR shall use the Fraud Reporting Forms attached to this Agreement, 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.

1-5.a.3. Pursuant to TCA § 71-5-2603(c) CONTRACTOR shall be subject to a civil penalty, to be imposed by OIG, for willful failure to report fraud by recipients, enrollees, applicants, or providers to OIG or MFCU, as appropriate.

1-5.a.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:

i. contact the subject of the investigation about any matters related to the investigation,
ii. enter into or attempt to negotiate any settlement or agreement regarding the incident, or
iii. accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

1-5.a.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.

1-5.a.6. 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.

1-5.a.7. The State shall not transfer its law enforcement functions to the CONTRACTOR.

1-5.a.8. The Contractor and health care providers, whether participating or non-participating providers, 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 health care provider, whether participating or non-participating, 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.

1-5.a.9. The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, the provider must comply with Section 1-5 of this Agreement.

1-5.a.10. Except as described in Section 2-3.k.6 of this Agreement, nothing herein shall require the CONTRACTOR to assure non-participating providers are compliant with TENNCARE contracts or state and/or federal law.

1-5. b. Fraud and Abuse Compliance Plan

1-5.b.1. The CONTRACTOR shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to TENNCARE. The CONTRACTOR's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR and submitted for review to TENNCARE within thirty (30) calendar days of the effective date of this Agreement 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. The State shall not transfer their law enforcement functions to the CONTRACTOR.

1-5.b.2. The fraud and abuse compliance plan shall:

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

ii. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;

iii. Contain procedures to prevent and detect fraud and abuse in the administration and delivery of services under this contract:

iv. Include a description of the specific controls in place for prevention and detection of fraud and abuse, such as:

a. Claims edits;
b. Post-processing review of claims;
c. Provider profiling and credentialing;
d. Prior authorization;
e. Utilization management;
f. Relevant subcontractor and provider agreement provisions;
g. Written provider and enrollee material regarding fraud and abuse referrals.

v. Contain provisions for the confidential reporting of plan violations to the designated person as described in this Agreement;

vi. 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;

vii. Ensure that the identities of individuals reporting violations of the plan are protected and that there is no retaliation against such persons;

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

ix. 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;

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

1-5.b.3. The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

1-5.b.4. The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

1-5.b.5. The CONTRACTOR shall submit an annual report to the Bureau of TennCare, Office of Contract Compliance and Performance, summarizing the results of its fraud and abuse compliance plan and other fraud and abuse prevention, detection, reporting, and investigation measures as required by 1-5 of this Agreement. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the CONTRACTOR's approved compliance plan.

1-6. Persons Eligible for Enrollment

Enrollee eligibility in TennCare shall be determined by TENNCARE and shall be limited to persons who meet the criteria described in TennCare policy and/or the TennCare rules and regulations and any Medicaid eligible authorized to be enrolled in a managed care organization under the authority of a 1915(b) waiver. For purposes of this Agreement, TENNCARE may define enrollees in specified categories for purposes of payments to the CONTRACTOR and/or enrollee eligibility for specified levels of services and benefits as well as cost share responsibilities.

TENNCARE reserves the right to carve out certain TennCare eligible populations, as described in TennCare Rules and Regulations, from the responsibilities described in this Agreement. At such time that individuals may be enrolled in the Program of All-inclusive Care for the Elderly (PACE), they shall no longer remain eligible to be enrolled in an MCO.

At such time that TENNCARE carves out certain additional populations, TENNCARE shall provide ninety (90) days advance notification to the CONTRACTOR, unless requirements of a court order or the enactment of a state law requiring implementation prevent such notice of said policy. If TENNCARE is unable to provide ninety (90) days advance notification of said changes, TENNCARE will provide as much notice as possible.

1-7. Previous Contract Requirements

Any Managed Care Organization that executed the September 11, 1995 Contractor Risk Agreement, as amended, with the State of Tennessee prior to the effective date of this Agreement is required to satisfy its responsibilities under the previous contract that have not been completed by the execution date of this Agreement. These requirements include, but shall not be limited to, the following:

1-7.a. Provisions related to executing an expenditure plan for distributing $12.40 per service provider per month at 3-10.b. of the Contractor Risk Agreement dated September 11, 1995, as amended, (see Attachment XIV);

1-7.b. Provisions related to the provision of services and appeals as described in Sections 2-3.a, 2-9, 3-10.b, and 4-8 of the Contractor Risk Agreement dated September 11, 1995, as amended.

1-7.c. Provisions related to the implementation of corrective action plans at 2-17 of the Contractor Risk Agreement dated September 11, 1995, as amended;

1-7.d. Provisions related to retention of the withhold at 3-10 of the Contractor Risk Agreement dated September 11, 1995, as amended.

To the extent specific reference is not made to a specific contract provision above, it is the intent of the parties that the CONTRACTOR remains obligated to fulfill any and all of its obligations during the effective period of the previous September 11, 1995 Contractor Risk Agreement, as amended, that have

not been satisfied. Any outstanding obligations remain in full force and effect, and the CONTRACTOR hereby agrees to be bound by such provisions which are incorporated herein by reference.

Execution of this Agreement shall not relieve the CONTRACTOR from its obligation to satisfy any requests for corrective action, obligation to pay liquidated damages, or the authority of TENNCARE to retain withholds for prior contract violations that have not been cured. Furthermore, the original date of notice of deficiency shall be used for the purpose of calculating liquidated damages and withholds.

SECTION 2 - CONTRACTOR RESPONSIBILITIES

2-1. General

The CONTRACTOR shall comply with all the provisions of this Agreement and amendments and shall act in good faith in the performance of the provisions of said Agreement. The CONTRACTOR shall respect the individual legal rights (including rights conferred by the Agreement) of every enrollee, regardless of the individual's family status as head of household, dependent, or otherwise. Nothing in this Agreement shall be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with aforementioned provisions 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, including but not limited to, Sections 1-5, 2-2, 2-3, 2-5, 2-8, 2-9, 2-10, 2-16, 2-17, 2-18, 2-22, 3-7, 3-10 and Section 4.

2-2. CONTRACTOR Qualifications

The CONTRACTOR shall comply with the following requirements at the inception of this Agreement and at all times during the life of this Agreement:

2-2.a. Be appropriately licensed to operate within the State of Tennessee;

2-2.b. Demonstrate the existence of a network of health care providers capable of providing comprehensive health care services as defined in this Agreement and in accordance with TennCare Program criteria for time/distance/location/patient volume, to all enrollees in the CONTRACTOR's plan;

Services shall, to the extent practical considering quality, accessibility and cost, be provided within the community service area(s) served by the MCO, unless otherwise authorized by TENNCARE;

2-2.c. Clearly demonstrate the capability and intent to provide or arrange for primary care case management services to TennCare eligible enrollees either by the organizational structure of the MCO using case managers or by primary care providers (PCPs), at the MCO's discretion, for all health care services provided to enrollees;

2-2.d. Assure availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area;

2-2.e. In accordance with Title 56, Chapter 32, Part 2, and Section 2-9.k.4, demonstrate sufficient financial capital to ensure uninterrupted delivery of health care on an ongoing basis;

2-2.f. Demonstrate sufficient network capability and a willingness, when so directed by TENNCARE, to accept a reasonable number of enrollees enrolled, or requesting enrollment, in any health plan

operating in the same community as the CONTRACTOR, including any plan which fails, is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the demonstrated capacity of the receiving MCO over the maximums described in Section 2-6, when the State determines that it is in the best interests of the TENNCARE program;

2-2.g. Comply with clear and measurable Provider Network, Claims Processing, Financial/Actuarial, Clinical/Quality and Member/Provider service standards of accountability defined by NCQA Standards and Guidelines, TENNCARE and as specified in this Agreement;

2-2.h. The CONTRACTOR shall provide the capability of electronic billing for all of their TennCare plans offered in Tennessee. The CONTRACTOR or any entities acting on behalf of the CONTRACTOR shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The CONTRACTOR shall comply at all times with standardized paper billing forms/format as follows:

Claim Type	**Claim Form**
Professional	CMS 1500
Institutional	UB-92
Pharmacy	NCPDP (Edit Format)
Dental	ADA

The CONTRACTOR shall not revise or modify the standardized form or format itself. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups. This shall include, but not be limited to, 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 which requires a statement that the provider certifies that s/he is aware that payment is from Federal and State funds and anyone who misrepresents or falsifies essential Medicaid claims information may be prosecuted under Federal and State laws.

As required in Sections 1-2, 2-3.w, 2-10.q and 4-1 of this Agreement, the CONTRACTOR also agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA). Further, 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 one hundred and eighty (180) days from notice by TENNCARE to do so.

The CONTRACTOR agrees to comply with prompt pay claims processing requirements in accordance with TCA 56-32-226.

Failure to comply with the aforementioned claims processing requirements shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16, and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 4-8 of this Agreement;

2-2.i. Agree to adhere to the quality standards and HEDIS preventive health standards that are required by TENNCARE. These standards shall be consistent with current NCQA Standards and Guidelines for the Accreditation of MCOs. Further, the CONTRACTOR shall agree to achieve and maintain NCQA Accreditation as described in Section 2-9.j.7 of this Agreement.

2-2.j. The CONTRACTOR shall demonstrate that it maintains health information systems that collects, analyzes, integrates, and reports data. The systems must provide information on areas applicable to the MCOs contractual requirements including, but not limited to, utilization, grievances and appeals and disenrollments. To the extent agreed upon by both parties and allowable by law, the CONTRACTOR agrees to provide TENNCARE online, read-only, real-time access to the information housed within the CONTRACTOR's information system to access the CONTRACTOR's TennCare data in a mutually agreed upon format and within a timeframe agreed upon by TENNCARE. TENNCARE and the CONTRACTOR shall work together to develop appropriate mechanisms to accomplish this requirement;

2-2.k. Agree to not require service providers to accept TennCare reimbursement amounts for services provided under any non- TennCare plan operated or administered by the CONTRACTOR;

2-2.l. Agree to report all provider related data required pursuant to this Agreement to TENNCARE using uniform provider numbers. The uniform numbers to be reported for all providers except pharmacy will be the National Provider Identifier (NPI) Number issued by CMS where applicable, and the traditional "Medicaid" provider number issued by TENNCARE. Prior to payment of a claim, the MCO shall require that providers that have not been enrolled in the TennCare Program previously as a Medicaid provider or as a provider who currently receives direct payment from TENNCARE (i.e., Medicare cost sharing) contact the Medicaid/TennCare Provider Enrollment Unit and obtain a "Medicaid" provider number. The issuance of a "Medicaid" provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply that TENNCARE has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of Pharmacy (NABP) number that has been assigned as well as the NPI number issued by CMS where applicable. The CONTRACTOR agrees to utilize CMS's newly established NPI numbers for all provider reporting purposes in accordance with timeframes established by CMS, including but not limited to, the development of contingency plans, beginning May 23, 2007 and the implementation of final plans thereafter;

2-2.m. Agree to display notices of the enrollee's right to appeal adverse actions affecting services in public areas of the CONTRACTOR's facility(s) in accordance with TennCare rules, regulations, policies and court orders;

2-2.n. The CONTRACTOR shall assure that one month prior to and throughout the annual MCO choice period, all communication and/or materials representing the CONTRACTOR's provider network shall accurately reflect the CONTRACTOR's provider network that will be available to enrollees on the enrollees' effective date. The CONTRACTOR shall not take action to disenroll an in-network primary care provider, specialist, or hospital provider to be included in the MCOs network for the upcoming calendar year after the first of September for one year except for the following:

2-2.n. 1. The provider has repeatedly failed to comply with the CONTRACTOR's policies and or procedures, the CONTRACTOR has received repeated and/or numerous enrollee complaints regarding the provider, there is reasonable suspicion that the provider is impaired due to drug or alcohol abuse or existing medical conditions, etc.; or

2-2.n. 2. The provider and the CONTRACTOR are unable to negotiate continuance of the provider agreement; or

2-2.n. 3. Provider requests disenrollment; or

2-2.n. 4. The provider has been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act; or

2-2.n. 5. The provider has lost his/her license, failed to report restriction of licensure or loss of privileges or is otherwise not in good standing with the TENNCARE program;

2-2.n. 6. The provider fails credentialing or re-credentialing; or

2-2.n. 7. Any other reason approved in writing by TENNCARE.

2-2.o. Agree to coordinate reimbursement to enrollees identified by TENNCARE who have incurred cost-sharing liabilities in excess of their out of pocket expenditure maximum;

2-2.p. Agree to educate primary care providers and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for EPSDT services and monitor compliance;

2-2.q. Agree to educate and encourage providers to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc) and adjust billing methodology according to described components of said procedure codes/modifiers; and

2-2.r. Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as they existed on April 16, 2002, unless otherwise directed or approved by TENNCARE, and to submit copies of all medical management polices and procedures in place as of April 16, 2002 to the State for the purpose of documenting medical management policies and procedures before final execution of this Amendment. Provider reimbursement rates, including all provider compensation rates, schedules and payments, shall be submitted to the Tennessee Department of Commerce and Insurance (TDCI) pursuant to T.C.A Section 56-32-232, for the purposes of TDCI's oversight of TennCare Health Maintenance Organizations and for examination and determination of the CONTRACTOR's compliance with Title 56, Chapter 32, Part 2 and Title 71, so long as the State shall be able to preserve the confidentiality of said information. Accordingly, it is the intent of TENNCARE that such information be governed by the confidentiality provisions of T.C.A. Section 56-32-235;

2-2.s. Agree to on-site review by TENNCARE, or its designated agent, before final execution of this Amendment;

2-2.t. Agree not to delegate responsibility for administrative activities after April 16, 2002 or enter into any Subcontractor agreements other than those in place on April 16, 2002, unless otherwise approved by TENNCARE;

2-2.u. The CONTRACTOR shall complete all necessary requirements to implement changes and process accurately all information necessary to successfully implement the Reform changes in accordance with state or federal law, rule or policy, including but not limited to benefit limits, cost sharing or copays or any other program change for which the MCO provides services. These changes shall be defined by TENNCARE. The CONTRACTOR agrees to test Reform changes prior to October 1, 2005. TENNCARE shall require the CONTRACTOR to track and report accumulated benefit information effective January 1, 2006; however, benefit limits shall not be imposed on enrollees prior to July 1, 2006 as described in Section 2-3.a.1(b) of this Agreement. Further, the CONTRACTOR shall adhere to the effective dates of the changes as described in Section 2-3.a.1 of this Agreement. Failure to successfully test and implement reform changes, as determined by TENNCARE, shall be considered breach of this Agreement

and the CONTRACTOR may be subject to termination in accordance with Section 4-2.b of this Agreement;

2-2.v. At such time that TENNCARE develops a provider fee schedule for use by all of the TennCare MCOs, the CONTRACTOR shall agree to implement, within a reasonable timeframe, said fee schedule; and

2-2.w. Mutually agree to such other requirements as may be reasonably established by TENNCARE.

2-3. Benefits/Service Requirements and Limitations

2-3.a. Covered Benefits

The CONTRACTOR shall cover, at a minimum, the following services and benefits:

2-3.a.1. TennCare Covered Benefits Chart

Effective July 1, 2006, benefits in the TennCare Program as provided by the CONTRACTOR are based on specified eligibility categories.

The CONTRACTOR shall cover, at a minimum, the services and benefits as outlined below.

2-3.a.1.(a) TennCare Benefits, prior to July 1, 2006:

SERVICE		BENEFIT
Inpatient Hospital Services		As medically necessary.
Outpatient Hospital Services		As medically necessary.
Physician Inpatient Services		As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure and services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx) or behavioral health services described in CPT procedure code range 96150 through 96155. CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
Lab & X-Ray Services		As medically necessary.
Newborn Services		As medically necessary including circumcisions performed by a physician.

Hospice Care		As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements. 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.
Dental Services		Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework or the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth). Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR. Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE, coverage shall be as follows: **Medicaid/Standard Eligible, Age 21 and older:** Non-covered. **Medicaid/Standard Eligible, Under age 21:** The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age. Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.

		(See Section 2-3.a.1, and 2-3.c.3)
Vision Services		Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.
Home Health Care		As medically necessary.
Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility)		As medically necessary. Non-covered therapeutic classes as described in Section 2-3.q, DESI, LTE, IRS drugs excluded. Effective July 1, 2000 through December 31, 2005, TENNCARE is responsible (whether directly or through a PBM) for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office.) TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category. Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics **only (not including services)** shall bill the PBM. Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003. The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid. Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE, the Benefit Limits for Pharmacy coverage, as provided by the PBM shall be as follows: **Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Pregnant Medically Needy Adults (Age 21 and older):** 5 Prescriptions per Month of which only 2 may be Brand name **Institutionalized Medicaid Adults (Age 21 and older):** As

		medically necessary **Medically Needy Non-Institutionalized, Non-Pregnant Adults (Age 21 and older):** Non-covered. **Standard Eligible, Age 21 and older:** Non-covered **Medicaid/Standard Eligible, Under age 21:** As medically necessary Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.
Durable Medical Equipment		As medically necessary. Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.
Medical Supplies		As medically necessary.
Emergency Ambulance Transportation		As medically necessary.
Non-Emergency Ambulance Transportation		As medically necessary.
Non-Emergency Transportation		As necessary for enrollees lacking accessible transportation for covered services. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process. At such time that TENNCARE carves out the CONTRACTOR's responsibility to provide Dental Services, the provision of transportation to and from said services shall remain with the CONTRACTOR.

Community Health Clinic Services		As medically necessary.
Renal Dialysis Services		As medically necessary.
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.		Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.
Rehabilitation Services		As medically necessary when determined cost effective by the MCO. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Chiropractic Services		When determined cost effective by the MCO.
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		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. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Sitter		As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and

		certification is made by a network physician that R.N. or L.P.N. is needed and neither is available. Effective August 1, 2005, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.
Convalescent Care		Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1) a Physician recommends confinement for convalescence; (2) the enrollee is under the continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care. Effective August 1, 2005, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.
Organ and Tissue Transplants and Donor Organ Procurement		As medically necessary for a covered organ and tissue transplant.
Reconstructive Breast Surgery		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 any surgical procedure on the non-diseased breast deemed necessary 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. Note: Applicable CPT procedure codes regarding the revision of undiseased breast following mastopexy or mastectomy for breast cancer, for the purpose of restoring symmetry, shall be the CPT procedures codes in the following range: 19316 – 19396.

2-3.a.1(b) TennCare Benefits, effective July 1, 2006:

Should TENNCARE eliminate a specified population from eligibility in the TennCare Program, Services/Benefits listed below shall no longer be applicable for said population.

SERVICE		BENEFIT
Inpatient Hospital Services		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are Not covered for adults. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative.

		Medicaid/Standard Eligible, Under age 21: As medically necessary, rehabilitation hospital facility services are covered under EPSDT for Medicaid eligible children and as medically necessary for Standard eligible children.
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.** **NOTE:** CONTRACTOR covered services shall include the following: • Services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). • Behavioral health services described in CPT procedure code range 96150 through 96155. • Medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.		**Medicaid/Standard 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 regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.
Preventive Care Services		As described in Section 2-3.a.4.

Lab and X-ray Services		**As medically necessary.**
Hospice Care		**As medically necessary.** Must be provided by a Medicare-certified hospice. Provided and reimbursed in accordance with state and federal requirements, including but not limited to the following: • 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; • The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and • 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.
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager.** **Medicaid/Standard Eligible, Age 21 and older:** Non-covered. **Medicaid/Standard Eligible, Under age 21:** The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age. Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR when the dental service is covered by the DBM. (See Section 2-3.a.1, and 2-3.c.3)
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), will be covered but shall be subject to the service limitations as described elsewhere in this Agreement. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be 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.

Home Health Care		**As medically necessary.**
Pharmacy Services		Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below. **Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Medically Needy Adults (Age 21 and older):** 5 Prescriptions per Month of which only 2 may be Brand name **Institutionalized Medicaid Adults (Age 21 and older):** As medically necessary **Standard Eligible, Age 21 and older:** Non-covered **Medicaid/Standard Eligible, Under age 21:** As medically necessary NOTE: Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage. Limits on Pharmacy benefits as well as the effective dates thereof are subject to change based on Waiver and/or Court negotiations. Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics **only (not including services)** shall bill the PBM. Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003. CONTRACTOR RESPONSIBILITIES: The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, 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 the Pharmacy Benefit Limits as described above. Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.

Durable Medical Equipment		**As medically necessary.** Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.
Medical Supplies		**As medically necessary.** Specified Medical Supplies shall be covered/non-covered in accordance with the 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 an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollees age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process. The CONTRACTOR shall provide transportation to and from Dental Services.
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/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 EPSDT 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 EPSDT requirements.
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 EPSDT 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 EPSDT 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.
Chiropractic Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with EPSDT requirements.
Sitter		**Medicaid/Standard Eligible, Age 21 and older: NON COVERED** **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary. Effective February 1, 2007, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.
Convalescent Care		**Medicaid/Standard Eligible, Age 21 and older: NON COVERED** **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary. Effective February 1, 2007, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.

2-3.a.2. Soft Limits/Service Thresholds for Certain Physical Health Services

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.

"Institutionalized Medicaid" are not subject to service thresholds and shall be defined as individuals who are receiving (as described in TennCare/Medicaid rules and regulations) long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services.

2-3.a.2(a) 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

2-3.a.3. Medical Necessity Determination

The CONTRACTOR shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the CONTRACTOR's ability to establish procedures for the determination of medical necessity or to use medically appropriate, cost effective alternative services, in accordance with Section 2-3.h, which have been approved by the Centers for Medicare & Medicaid Services. The determination of medical necessity shall be made on a case by case basis. Except for benefit limits as may be described in Section 2-3.a, 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 when medically necessary based on a patient's individual characteristics. 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. The CONTRACTOR may deny services that are non-covered except as otherwise required by EPSDT or unless otherwise directed to provide by TENNCARE and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the definition of medical necessity as described in this Agreement.

All medically necessary services shall be covered for enrollees under 21 years of age in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

2-3.a.4. Preventive Services

The following preventive medical services (identified by applicable CPT procedure code and ADA procedure code) shall only be covered in accordance with Section 2-3.a.1 of this Agreement and subject to any limitations described herein, within the scope of standard medical practice, and shall be exempt from any cost sharing responsibilities as described in Section 2-3.i of this Agreement. In the event that the CPT codes listed below should be revised, consolidated, separated into individual parts, or replaced in part or in whole by new CPT codes, the services represented by the CPT codes listed below shall remain covered services. It is the responsibility of the CONTRACTOR to assure claims and encounter data reflects current CPT coding. Vision services, hearing services, and laboratory services not specifically listed herein, which are required for TennCare Medicaid enrollees pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" periodicity schedule for such services. Dental services which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. It is the responsibility of the MCO to educate providers as to the importance and necessity of documenting all of the components of the screen, and of using the appropriate codes as directed by TENNCARE to the MCOs. It is also the responsibility of the MCO to communicate this data to TENNCARE as directed.

Preventive Services (excluded from cost sharing)

NEW PATIENT	ESTABLISHED PATIENT
99381 – Initial evaluation < 1 year	99391 – Periodic reevaluation <1 year
99382 – age 1 through 4 years	99392 – age 1 through 4 years
99383 – age 5 through 11 years	99393 – age 5 through 11 years
99384 – age 12 through 17 years	99394 – age 12 through 17 years
99385 – age 18 through 39 years	99395 – age 18 through 39 years
99386 – age 40 through 64 years	99396 – age 40 through 64 years
99387 – age 65 years and over	99397 – age 65 years and over

Counseling and Risk Factor Reduction Intervention (excluded from cost sharing)

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Family Planning Services - If not part of a Preventive Services office visit, should be billed using the Counseling and Risk reduction individual codes (99401-99404). Family planning supplies and prescription drugs are also exempt from cost sharing responsibilities.

Prenatal Care (excluded from cost sharing)

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	" including post partum care
59425	Antepartum care only, 4-6 visits
59426	Antepartum care only, 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Other Preventive Services (excluded from cost sharing)

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90476 – 90749	Immunizations
90465-90474	Immunization administration
99173	Screening test of visual acuity, quantitative, bilateral <21 years of age
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only
76090-76092	Mammography Screening
88141-88145, 88147,88148, 88150,88152-88155, 88164-88167,88174-88175	Cervical Cancer Screening

Laboratory: Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes.

Preventive Dental Services for Children Under 21 Years of Age (excluded from cost sharing)

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

2-3.b. Availability and Accessibility of Services

The CONTRACTOR shall make services, service locations, and service sites available and accessible to provide the covered (specialized or otherwise) services. Accessibility shall be in accordance with the Terms and Conditions for Access which is part of the TennCare Waiver and as contained herein as Attachment III unless TENNCARE has specified more stringent access criteria in the Agreement or the Amendments thereto. The CONTRACTOR must provide or arrange for the provision of all of the services described as covered in this Agreement. Should the CONTRACTOR's provider network be unable to provide necessary medical services covered under this Agreement to a particular enrollee, the CONTRACTOR must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the enrollee can be safely transferred, the CONTRACTOR may transfer the enrollee to an appropriate contracted service provider.

2-3.b.1. Primary Care Providers (PCPs)

(a) 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 1-3, who is responsible for coordinating the covered services provided to the member.

(b) The CONTRACTOR shall assure that there are PCPs, willing and able to provide the level of care and range of services necessary to meet the medical 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.

(c) The CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.

(d) 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 1-3.

(e) 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.

(f) 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.

(g) 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.

2-3.b.2. Specialty Service Providers

(1) Essential Hospital Services and Centers of Excellence

(a) 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:

(i) neonatal services;
(ii) perinatal services;
(iii) pediatric services;
(iv) trauma services; and
(v) burn services.

(b) 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) Physician Specialists

The CONTRACTOR shall establish and maintain a network of physician specialist that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the health care needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

(a) 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

(b) The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, and IV.

(3) TENNCARE Monitoring

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 2-10.c.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.

(a) TENNCARE will require a corrective action plan from the CONTRACTOR when:

(i) 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;

(ii) 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

(iii) The member to provider ratio exceeds that listed in Attachment IV.

(b) 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:

(i) The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;

(ii) 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;

(iii) 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;

(iv) 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;

(iv) 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;

(v) Documentation of how these arrangements are communicated to the member; and

(vi) Documentation of how these arrangements are communicated to the PCPs.

(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.

2-3.b.3. Availability and Accessibility of Emergency Medical Services

Emergency medical services shall be available twenty-four (24) hours a day, seven (7) days a week.

2-3.c. Specialized Services

The following specialized services shall be provided according to the following provisions:

2-3.c.1. Children At Risk Or In DCS Custody

Children who are in state custody or who are at risk of entering state custody are eligible for participation in the Children's Plan. The Children's Plan is administered by the Department of Children's Services which was established May 23, 1996. As with any other enrollee under the age of twenty-one (21), the CONTRACTOR is responsible for all medically necessary covered services to the TennCare enrollee. Recognizing the vulnerability of this special population, these children may require more services than children who are not in the Children's Plan.

2-3.c.1.(a) Assignment of MCO as Primary Care Manager

When children are placed in custody, the TennCare address on file is the home county address where the child was legally adjudicated. (A child placed into custody in Rutherford County will have an address designated by a case manager in Rutherford County.) Sometimes children in state custody may need to move away from that home county to be placed in a foster home, or to receive residential services. They may later move back to the home county during a period of attempted family reunification or when they are stable. Because they do sometimes move, the PCP assignment must be changed so they may access services. In order to accommodate this issue, the CONTRACTOR may assign the MCO as the primary care provider or case manager in lieu of a specific primary care provider, children may be assigned to a case manager at the MCO level or to a predefined group of primary care providers in lieu of a specific primary care provider. This global MCO assignment would then permit the child access to services without a needed change with relocation. The CONTRACTOR may make the DCS case manager or Health Advocacy Units aware of available primary care providers, and DCS may access these providers. See discussion of Best Practice Network below (Section 2-3.c.1.(b)(2), (3), and (4). The contractors designated DCS liaison (as described in Section 2-9.c.5) may coordinate this effort with DCS.

2-3.c.1(b) Remedial Plan

The CONTRACTOR will participate fully in the implementation of the Remedial Plan for Children in Custody as filed with the Federal Court on May 12, 2000 or as subsequently amended. "Participation" includes, but is not limited to, the following requirements:

2-3.c.1(b) (1) The CONTRACTOR must contract with each Center of Excellence (COE) for provision of tertiary level medically necessary covered

services to DCS custody children and children at risk of state custody. Such services shall include ongoing specialized care when requested by local providers; multidisciplinary evaluation and diagnostic services; consults to the providers managing the child's care; and case coordination of services offered. Children will be referred to the COE when needed specialists with appropriate training and experience are not available. The COE can determine when a specialist can serve as PCP on special cases where this is deemed in the child's interest and the specialist is willing to accept this role. The COE can also determine whether a service which has been ordered for a DCS custody child and which has been denied by the CONTRACTOR can be initiated while an appeal is still pending. In order to improve understanding and cooperation between the CONTRACTOR and the COE, the CONTRACTOR will provide information to the COE on the procedures and tools that the CONTRACTOR uses in making utilization review determinations.

2-3.c.1(b)(2) The CONTRACTOR must insure that each DCS custody child is assigned to a Best Practice Network (BPN) PCP.

2-3.c.1(b)(3) The CONTRACTOR must maintain a provider network with adequate capacity to deliver covered services which meet the special needs of children in state custody. Indicators of an adequate network include the following:

(i) The CONTRACTOR has enough providers to consistently meet the timeline of scheduling EPSDT screenings for DCS custody children within three (3) days of the child's entry into custody (children in custody will be assigned to BPN PCPs);

(ii) The CONTRACTOR has sufficient providers to be able to consistently deliver services to custody children ordered by a provider in its own network, a BPN provider, or a Center of Excellence within the timeframes set out elsewhere in this CONTRACT; and

(iii) The CONTRACTOR has within its network specialized health providers with sufficient expertise to deliver the covered services recognized in Best Practice Guidelines as being proven effective and needed by children in custody.

2-3.c.1(b)(4) The CONTRACTOR must contract with all Best Practice Network providers unless it can demonstrate to the satisfaction of the Implementation Team that its existing network is adequate. If the CONTRACTOR can demonstrate to the satisfaction of the Implementation Team that its network partially satisfies the adequacy requirements (e.g., in a particular geographic area or medical specialty), but not entirely, the Implementation Team, at its discretion, can excuse the CONTRACTOR from contracting with BPN providers in those areas in which the CONTRACTOR's network is adequate.

2-3.c.1(b)(5) The COE may order TennCare covered services for DCS custody children whom it is treating or diagnosing. The COE must follow the CONTRACTOR's procedures with respect to requests for prior authorization, etc. If the CONTRACTOR denies coverage of the service

but the COE believes the service should be delivered, the COE can begin the service or arrange for a provider in the CONTRACTOR network to begin the service. The provider to be used will be discussed with the CONTRACTOR to assure that that provider is still a participant in the CONTRACTOR's network and in good standing with the CONTRACTOR. The COE will initiate an expedited appeal for the service if it is providing the service. If the appeal decision determines that the CONTRACTOR is responsible for providing the service, then the CONTRACTOR will pay for the service. If the appeal decision determines that the CONTRACTOR is not responsible for providing the service, then the state will pay for the service and will not claim Federal Financial Participation (FFP) for this expenditure.

2-3.c.1(b)(6) If a BPN provider requests a service that requires prior authorization and the service is denied by the CONTRACTOR, then:

(i) The BPN will contact the COE and review the case with a faculty member for medical necessity;

(ii) If the COE concurs with the CONTRACTOR that the service is not medically necessary or not covered, the COE will work with the BPN to assess whether an alternative service is necessary and, if so, to determine an alternative, but appropriate, service to order;

(iii) If the COE concurs with the BPN provider that the ordered service is covered and medically necessary, then the COE will contact the CONTRACTOR for approval;

(iv) If the CONTRACTOR denies coverage of the service, the COE can begin to provide the service or authorize a provider of the CONTRACTOR network to begin the service; and

(v) The COE will begin an expedited appeal for the service if the COE is the provider of the services. If the appeal decision determines that the CONTRACTOR is responsible for providing the service, then the CONTRACTOR will pay for the service. If the appeal decision determines that the CONTRACTOR is not responsible for providing the service, then the state will pay for the service and will not claim Federal Financial Participation (FFP) for this expenditure.

2-3.c.1(b)(7) When, pursuant to the Remedial Plan for Children in Custody, services are provided when deemed appropriate regardless of CONTRACTOR denial, the CONTRACTOR will be allowed to appeal decisions found against it to a neutral party designated by the state. However, the outcome of the process shall not affect the interests of the child, who shall receive the services in question without regard to whether the CONTRACTOR or a state agency is ultimately determined to be financially responsible.

2-3.c.1(b)(8) The CONTRACTOR must include in its subcontracts and agreements with providers a provision which states that subcontractors and providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare.

2-3.c.1(b)(9) When a child at risk of state custody is disenrolled from the CONTRACTOR's plan, the CONTRACTOR shall notify the child's primary care provider and request that the PCP forward a copy of the child's medical record upon receipt of notice from TENNCARE or DCS.

2-3.c.2. Mental Health/Substance Abuse Services

All mental health related services and substance abuse services provided to enrollees, unless otherwise specified in this Section 2-3.c.2, shall be the responsibility of Behavioral Health Organizations (BHOs) who have a contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State. These services include:

- Psychiatric Inpatient Facility Services;
- Physician Psychiatric Inpatient Services;
- Outpatient Mental Health Services;
- Inpatient and Outpatient Substance Abuse Treatment Services;
- Psychiatric Pharmacy Services and Pharmacy Related Lab Services;
- Transportation to Covered Mental Health Services;
- Mental Health Case Management;
- 24-Hour Residential Treatment;
- Housing/Residential Care;
- Specialized Outpatient and Symptom Management;
- Specialized Crisis Services; and
- Psychiatric Rehabilitation Services.

Effective July 1, 2002, behavioral health related services provided to enrollees by an MCO Primary Care Provider shall not be the responsibility of Behavioral Health Organizations (BHOs). As some MCO Primary Care Providers may appropriately treat or manage an enrollee's behavioral health condition, and in an effort to minimize administrative complexities for those Primary Care Providers (PCPs), the CONTRACTOR shall be responsible for services provided to enrollees by their network PCPs. CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). Accordingly, the CONTRACTOR shall direct its network PCPs and approved providers to submit claims for covered services with a **primary** behavioral diagnosis code, defined as ICD-9-CM 290.xx – 319.xx (and subsequent revisions thereto), to the CONTRACTOR for payment. The CONTRACTOR agrees to timely process said claims in accordance with Section 2-9.m.

The MCO shall encourage its PCPs, at their discretion, to contact the BHO for consultation on any covered Mental Health and Substance Abuse condition/service. The PCPs shall also be encouraged to refer to the BHO, for coordination of treatment of any covered Mental Health and Substance Abuse condition/service, for any and all of its members in accordance with its contracts with TDMHDD when those services can be provided by Mental Health Professionals.

The carve out of mental health and substance abuse services provided by PCPs and/or approved providers from the BHO benefit package shall not relieve the BHO from the responsibility to assist in the coordination of mental health and substance abuse care and medical care of enrollees; nor shall it prohibit PCPs from referring enrollees to a mental health or substance abuse provider in the BHO's network when determined necessary by the PCP.

The CONTRACTOR is responsible for the costs and provision of covered services that are not mental health or substance abuse services, and covered services provided by a network PCP with

a primary behavioral health diagnosis code as specified above. The carve out of all other mental health and substance abuse services shall not relieve the CONTRACTOR from the responsibility to assist in the coordination of mental health and medical care of enrollees. The MCO and BHO shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services. The MCO and BHO shall cooperate with the State's efforts to facilitate delivery of mental health services to the TennCare population and shall agree to abide by the MCO/BHO Coordination Provisions outlined herein for purposes of interfacing with each other and assuring coordination of care, case management and continuity of care for purposes of coordinating appropriate health care.

2-3.c.2.(a) Services And Responsibilities

Coordination of physical health care and mental health care shall, at a minimum, include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);
- Maintenance of confidentiality; and
- Cooperation with the BHOs regarding training activities provided by the BHOs.

2-3.c.2.(b) Operating Principles

The CONTRACTOR recognizes that the BHO shall support the MCO and all of its providers in their delivery of behavioral health services to all TennCare members by, but not limited to, providing advice, consultation, and assistance in coordinating the delivery of behavioral health services. Coordinating the delivery of behavioral health services to TennCare members is the primary responsibility of the BHO. To ensure such coordination, the BHO shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, TDMHDD, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with the care coordinator. Each MCO shall be responsible for communicating the BHO provider services and/or claim coordinator contact information to all of its providers, including PCPs. With respect to specific member services, including transfer of responsibility for services from the PCP to the BHO, resolution of problems shall be carried out between the PCP (or MCO representative) and the BHO coordinator. Should systemic issues arise, the MCO and the BHO agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the BHO shall meet with TDMHDD and TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within 90 days from referral to TDMHDD or TennCare.

2-3.c.2.(b)(1) <u>Resolution of Requests for Authorization for non-PCPs delivering Behavioral Health services.</u> The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or 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 member. BHO and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require coordination between BHO and MCO. The BHO and MCO shall provide the other party with a list of its Care Coordinators and telephone number(s) at which each Care

Coordinator may be contacted. When either party receives a request for authorization from a provider for a member and the party believes care is the responsibility of the other party, the Care Coordinator for that party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization and communicate to the enrollee or enrollee's provider for routine requests which shall be made within 21 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The BHO and MCO will establish a coordination committee to address all issues of 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 parties will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting authorization of a service. In the event the parties cannot agree within 15 days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the Bureau of TennCare. Both parties are responsible for enforcing hold harmless protection for the member. The parties agree that any response to a request for authorization shall not exceed 21 days and shall comply with the Grier Revised Consent Decree.

2-3.c.2.(b)(2) Claim Resolution Authorization for non-PCPs delivering Behavioral Health services. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between BHO and MCO (parties). The BHO and MCO shall provide the other party, TDMHDD, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

When either party receives a disputed claim for payment from a provider for a member and the party believes care is the responsibility of the other party, the Claims Coordinator for that party will contact the respective Claims Coordinator of the other party within four (4) business days of receiving such claim for payment. If the Claims Coordinators are unable to reach agreement on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee for review.

The BHO and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. 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 will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial referral to the Claim Coordination Committee, said claim shall be referred to the Chief Executive Officers (CEO) or the CEO's designee, of both BHO and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

If the meeting between the CEOs, or their designee(s), of the BHO and MCO does not successfully resolve the dispute within 10 days, the parties shall, within fourteen (14) days after the meeting among the CEOs or their designee(s), submit a request for resolution of the dispute to the state or the state's designee for a decision on responsibility after the service has been delivered.

The process as described above shall be completed within 30 days of receiving the claim for payment. In the event the parties cannot agree within 30 days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection 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 within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and BHO's respective Agreements 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.

The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and 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.

The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. ("Decision"). The "Decision" may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the BHO which 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 ($1000) for each request for resolution. The amount of the CONTRACTOR's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the CONTRACTOR's payment responsibility as described in this section within (30) calendar days of the date of the state's Decision, the state may deduct amounts of the CONTRACTOR's payment responsibility from any current or future amount owed the party.

2-3.c.2(b)(3) Denial, Delay, Reduction, Termination or Suspension. The parties agree 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 medical services specified in this Agreement.

2-3.c.2(b)(4) Emergencies. Prior authorization shall not be required for emergency services prior to stabilization.

2-3.c.2(b)(5) Claims Processing Requirements. All claims must be processed in accordance with the requirements of the MCO's and BHO's respective Agreements with the State of Tennessee.

2-3.c.2(b)(6) 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, T.C.A. §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.

2-3.c.2(b)(7) Duties and Obligations. The existence of any dispute under this Agreement shall in no way affect the duty of the parties to continue to perform their respective obligations, including their obligations established in their respective contracts with the state pending resolution of the dispute under this Section. In accordance with T.C.A. § 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.

2-3.c.2(b)(8) Confidentiality. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or 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 BHO and MCO standards. These standards will apply to both BHO's and MCO's providers and staff. If

either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The BHO and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee which is provided to or obtained by or through the MCO's or BHO's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section 4-22 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to TDMHDD, the TennCare Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, 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 enrollee or potential enrollee.

2-3.c.2.(b)(9) Access to Service. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State, to establish methods of referral which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2-3.c.3 Coordination of Dental Benefits

It is the intent of TENNCARE to contract directly with a dental benefits manager (DBM) and assume responsibility for the provision and payment of dental benefits effective September 1, 2002. However, the CONTRACTOR shall maintain an adequate network for the provision of dental benefits until such time that TENNCARE provides the CONTRACTOR with written notice that TENNCARE will assume said responsibilities.

At such time that TENNCARE carves out the CONTRACTOR's responsibility to provide Dental Services, the provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service shall remain with the CONTRACTOR. The CONTRACTOR shall agree to coordinate dental and medical services in accordance with the following provisions.

The dental benefits manager (DBM) shall be responsible for: (1) authorizing dental services for which they have the responsibility to pay; and (2) arranging services to be provided, when appropriate, with providers that are contracted in the CONTRACTOR's plan. The CONTRACTOR shall be responsible for authorizing said services that require transportation, 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.

2-3.c.3.(a) Services And Responsibilities

Coordination of dental services, at a minimum, include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);
- Maintenance of confidentiality; and
- Cooperation with the DBM regarding training activities provided by the DBM.

2-3.c.3.(b) Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM. To ensure such coordination, the DBM shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with that coordinator. Each MCO shall be responsible for communicating the DBM provider services and/or claim coordinator contact information to all of its providers. With respect to specific member services, resolution of problems shall be carried out between the MCO coordinator and the DBM coordinator. Should systemic issues arise, the MCO and the DBM agree to meet and resolve these issues. 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 90 days from referral to TENNCARE.

2-3.c.3.(b)(1) Resolution of Requests for Authorization. The MCO agrees and recognizes that the DBM shall agree 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 member. DBM and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require coordination between DBM and MCO. The DBM and MCO shall provide the other party with a list of its Care Coordinators and telephone number(s) at which each Care Coordinator may be contacted. When either party receives a request for authorization from a provider for a member and the party believes care is the responsibility of the other party, the Care Coordinator for that party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization and communicate to the enrollee or enrollee's provider for routine requests which shall be made within 21 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The DBM and MCO will establish a coordination committee to address all issues of 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 parties will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting authorization of a service. In the event the parties cannot agree within 15 days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the Bureau of TennCare. Both parties are responsible for enforcing hold harmless protection for the member. The parties agree that any

response to a request for authorization shall not exceed 21 days and shall comply with the Grier Revised Consent Decree.

2-3.c.3.(b)(2) Claim Resolution Authorization. The MCO agrees and recognizes that the DBM shall agree through its contractual arrangement with the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between DBM and MCO (parties). The DBM and MCO shall provide the other party, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

When either party receives a disputed claim for payment from a provider for a member and the party believes care is the responsibility of the other party, the Claims Coordinator for that party will contact the respective Claims Coordinator of the other party within four (4) business days of receiving such claim for payment. If the Claims Coordinators are unable to reach agreement on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee for review.

The DBM and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. 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 will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial referral to the Claim Coordination Committee, said claim shall be referred to the Chief Executive Officers (CEO) or the CEO's designee, of both DBM and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within 10 days, the parties shall, within fourteen (14) days after the meeting among the CEOs or their designee(s), submit a request for resolution of the dispute to the state or the state's designee for a decision on responsibility after the service has been delivered.

The process as described above shall be completed within 30 days of receiving the claim for payment. In the event the parties cannot agree within 30 days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection 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 within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements 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.

The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and 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.

The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. ("Decision"). The "Decision" may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the DBM which 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 ($1000) for each request for resolution. The amount of the CONTRACTOR's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the CONTRACTOR's payment responsibility as described in this section within (30) calendar days of the date of the state's Decision, the state may deduct amounts of the CONTRACTOR's payment responsibility from any current or future amount owed the party.

2-3.c.3(b)(3) D<u>enial, Delay, Reduction, Termination or Suspension.</u> The parties agree 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 medical services specified in this Agreement.

2-3.c.3(b)(4) Emergencies. Prior authorization shall not be required for emergency services prior to stabilization.

2-3.c.3(b)(5) Claims Processing Requirements. All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee.

2-3.c.3(b)(6) 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, T.C.A. §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.

2-3.c.3(b)(7) Duties and Obligations. The existence of any dispute under this Agreement shall in no way affect the duty of the parties to continue to perform their respective obligations, including their obligations established in their respective contracts with the state pending resolution of the dispute under this Section. In accordance with T.C.A. § 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.

2-3.c.3(b)(8) Confidentiality. The MCO agrees and recognizes that the DBM shall agree 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 will apply to both DBM's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The DBM and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee 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 Title 33, Tennessee Code Annotated, Section 4-22 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to the TennCare Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, 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 enrollee or potential enrollee.

2-3.c.3(b)(9) Access to Service. The MCO agrees and recognizes that the DBM shall agree through its contractual arrangement with the State, to establish methods of referral which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2-3.c.4 Coordination of MCO and PBM Benefits

In order to assure enrollees assigned to TennCare MCOs continue to receive pharmacy services without interruption during the transition and future coordination of their pharmacy benefits, each MCO shall be required to cooperate in any manner necessary, including but not limited to the following:

(a) The CONTRACTOR and/or its subcontractor (PBM) shall coordinate and interface with TENNCARE and/or the TennCare contracted PBM in order to exchange data in a media and format acceptable to TENNCARE for the purpose of transitioning necessary information such as authorization requests, refill limits, etc.

(b) The CONTRACTOR agrees to assure it's providers shall coordinate with the TennCare PBM regarding authorization requests for pharmacy services.

(c) The CONTRACTOR shall be capable of accepting and maintaining data sent from TENNCARE and/or the TennCare PBM regarding enrollee utilization of pharmacy services. The CONTRACTOR shall utilize pharmacy data for management of enrollee health care.

(d) The CONTRACTOR shall obtain a report from the pharmacy benefits manager (PBM) when provided by the TennCare PBM, that identifies prescribers who have been listed in the top one-hundred (100) prescribers for three (3) weeks out of a four (4) consecutive week period as having prescribed prescription drugs that are not on the Preferred Drug List (PDL). The CONTRACTOR shall use this report as a basis to contact, by telephone one-hundred percent (100%) of its network prescribers (or a provider practicing with the prescribing physician), within thirty (30) calendar days from the date the report is received, for the purpose of educating the physician about a prescription drug that is on the PDL that the physician may prescribe as an alternative and to encourage the physician to contact the pharmacy and change the prescription accordingly; any prescriber who cannot be identified through a unique DEA number shall be excluded from this requirement.

(e) CONTRACTOR shall utilize pharmacy lock-in data provided by TENNCARE PBM to identify members for case management services.

(f) Appeals and member service inquiries related to pharmacy services, provided by the TennCare PBM, shall be the responsibility of TENNCARE and/or the TennCare PBM.

2-3.c.5 Coordination with the Department of Education

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. 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:

(a) 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.

(b) 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.

(c) 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).

2-3.d. Prior Authorization for Covered Services

2-3.d.1. General Rule

The CONTRACTOR and/or its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, subcontractor or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee 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. Prior Authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 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. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must 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 health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

2-3.d.2. At time of Enrollment

In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered 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 within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the

services beyond thirty (30) days. Care rendered to a CONTRACTOR's enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed.

2-3.d.3. Prenatal Care

In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care 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 within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period.

The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

2-3.d.4. Notice of Adverse Action Regarding Prior Authorization Requests

The CONTRACTOR must clearly document and communicate the reasons for each denial in a manner sufficient for the provider and member to understand the denial and decide about appealing the decision. Notice of adverse actions to providers and members regarding prior authorization requests shall be provided within the following guidelines:

(a) Provider Notice. The CONTRACTOR must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing; however, the CONTRACTOR must make a reviewer available to discuss any denial decisions. Information provided to the provider must include how to contact the reviewer.

(b) Enrollee Notice. See notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

2-3.d.5 Appeals related to Prior Authorization/Medical Necessity Denials

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 provider 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. Documentation of such action will be made available to TENNCARE, upon request. Providers who do not provide requested medical record information for purposes of making a medical necessity determination for a particular medical item or service, shall not be entitled to payment for the provision of such medical item or service.

Upon request by TENNCARE in support of making a decision relative to a medical appeal, the CONTRACTOR must provide TENNCARE with individualized medical record information from the treating health care provider(s). The CONTRACTOR must take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable regulation, 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 enrollee, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2-3.e. Additional Services and Incentives

The CONTRACTOR shall not advertise, offer or provide any services or incentives not required or permitted pursuant to Sections 2-3.a or 2-3.h of this Agreement in addition to the required services that are covered within the scope of this Agreement except when such services, benefits or incentives have been specifically prior approved in writing by TENNCARE. Examples of services, benefits or incentives that may be approved by TENNCARE shall include, but are not limited to, educational programs intended to reduce the frequency or acuity of treatment for one or more specified medical conditions and any accompanying incentives given to enrollees to encourage participation in such educational programs.

2-3.f. Institutional Services and Alternatives to Institutional Services

Long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services are not covered by this Agreement and shall not be the responsibility of the CONTRACTOR. These services shall be provided to qualified individuals as described in TennCare/Medicaid rules and regulations through contracts between TENNCARE and the appropriate facilities that provide these services. Convalescent care, as described in Section 2-3.a.1 of this Agreement, is considered to be short-term care and is not considered to be "long-term care institutional services" for purposes of this section. Room and board expenses (including nursing care) in a nursing facility provided under the hospice benefit are not considered to be long-term care institutional services. Enrollees requiring long term care institutionalization or the HCBS waiver alternative shall be eligible for participation in the CONTRACTOR's plan for all MCO covered services and such services shall be the CONTRACTOR's responsibility. Those TennCare covered benefits which are not included in the Bureau of TennCare's per diem reimbursement for institutional services through the Long-Term Care Program shall be the responsibility of the CONTRACTOR (e.g., prosthetics, some items of durable medical equipment, non–emergency ambulance transportation, and non-emergency transportation). TennCare covered benefits that are not provided by TENNCARE through the aforementioned contracts shall be the responsibility of the CONTRACTOR.

2-3.g. Coordination with Medicare

2-3.g. 1. The CONTRACTOR is responsible for coordinating TennCare-covered benefits with benefits offered by other insurance, including Medicare, which the enrollee may have. For Medicaid eligibles, such coordination must insure that TennCare-covered services are delivered without charge to the enrollee.

2-3.g. 2. TENNCARE is responsible for paying Medicare premiums, deductibles, and coinsurance for enrollees who are dually eligible for Medicaid and Medicare.

2-3.g. 3. TENNCARE is not responsible for paying Medicare premiums, deductibles, and coinsurance for enrollees who have Medicare but who are not also eligible for Medicaid. These costs are the responsibility of the enrollee. Until January 1, 2003, the CONTRACTOR may cover these costs as a cost-effective alternative service to take advantage of Medicare covered services, if said costs are lower than the cost of the service without Medicare coverage. The CONTRACTOR agrees that TENNCARE may require that the CONTRACTOR cover these costs as a cost-effective alternative service if determined by TENNCARE to be appropriate.

2-3.h. Use of Cost-Effective Alternative Services

The CONTRACTOR shall be allowed to use alternative services, whether listed as covered or non-covered or omitted in Section 2-3.a of this Agreement when the use of such alternative services is medically appropriate and is cost-effective. The Medical Fund Target described elsewhere in this Agreement shall not be increased or decreased because of the use of alternative services.

2-3.i. Cost Sharing for Services

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare 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 MCO or non-payment by the State to the MCO. Further, the CONTRACTOR and all providers and subcontractors may not charge enrollees for missed appointments.

TennCare cost sharing responsibilities shall apply to services other than the preventive services described in Section 2-3.a.4 of this Agreement. The current cost share schedule to be used in determining applicable cost sharing responsibilities is included in this Agreement as Attachment XI.

Effective for services provided on or after January 1, 2001, the CONTRACTOR shall be expressly prohibited from waiving or using any alternative TennCare cost sharing schedules, unless required by TENNCARE, regardless of whether or not the CONTRACTOR has been previously approved by TENNCARE to do so.

If, and at such time that TENNCARE amends any TennCare rules or regulations, including but not limited to the TennCare cost sharing rules and regulations, the rules shall automatically be incorporated into this Agreement and become binding on the MCO and the MCO's providers.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for TennCare covered services, including but not limited to, services that the State or the MCO has not paid for except as permitted by TennCare rules and regulations 1200-13-13-.08, 1200-13-14-.08 and as described below. Providers may seek payment from an enrollee only in the following situations:

1. If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider is required to 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; or

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; or

3. If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost share amounts must be refunded when a claim is submitted to an MCO if 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); or

4. If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

   (a) The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry;

   (b) The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested, and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:

      (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect;

      (ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect;

      (iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect.

   (c) The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Then and thereafter, within the remainder of the period applicable to that benefit limit, the provider may continue to bill the enrollee for services within that same exhausted benefit

category without having to submit, for repeated MCC denial, claims for those subsequent services.

(d) The provider had previously taken the steps in parts 1., 2., or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.

The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, once a CONTRACTOR becomes aware the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the CONTRACTOR, if a provider continues to bill an enrollee, the CONTRACTOR shall refer the provider to the TBI.

2-3.j. Primary Care Providers/Case Management/Continuity of Care

The CONTRACTOR shall provide primary care case management services to TennCare eligible enrollees. The CONTRACTOR shall be responsible for the management of medical care and continuity of care for all its TennCare enrollees. Primary care case management services include the management of medical care and continuity of care for TennCare enrollees.

2-3.j.1. Primary Care Providers

2-3.j.1(a) To the extent feasible and appropriate, the CONTRACTOR agrees to offer each enrollee a choice of a primary care provider.

2-3.j.1(b) The CONTRACTOR shall establish policies and procedures to enable enrollees reasonable opportunities to change primary care providers. Such policies and procedures may not specify a length of time greater than twelve (12) months between changes under normal circumstances. If a time restriction for change is imposed, the CONTRACTOR must include provisions for more frequent changes with good cause.

2-3.j.1(c) Primary care providers may include licensed physicians as well as registered professional nurses and physician assistants practicing in accordance with state law.

2-3.j.1(d) Each enrollee must have an identified primary care provider with the exception of the dually eligible Medicare/Medicaid enrollees and children in state custody. If an enrollee is not dually eligible for Medicare and Medicaid or is not a child in state custody and fails or refuses to select a primary care provider from those offered within thirty (30) days of enrollment, the CONTRACTOR shall assign a primary care provider. The CONTRACTOR may assign a PCP in less than thirty (30) days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.

2-3.j.1(e) Children in state custody may be assigned to a case manager at the MCO level or to a pre-defined group of primary care providers in lieu of a specific primary care provider.

2-3.j.1(f) Additionally, other vulnerable populations (e.g., persons with special needs such as multiple handicaps, or acute chronic conditions, etc.) may be assigned to a case manager at the MCO level or, at the MCO's discretion, to their attending specialist as their primary care provider. However, the CONTRACTOR shall comply with Section 2-3.j.3(g) regarding enrollees determined to need a course of treatment or regular care monitoring.

2-3.j.2. Management of Medical Care and Coordination of Care

The CONTRACTOR shall be responsible for the management of medical care and continuity of care for all its TennCare enrollees through the following minimum functions:

2-3.j.2(a) Performance of reasonable preventive health case management services, as well as mechanisms to assess the quality and appropriateness of care furnished, appropriate referral and scheduling assistance of enrollees with special health care needs, including those identified through the provision of preventive services;

2-3.j.2(b) Documentation of authorized referral services in utilization management system;

2-3.j.2(c) Monitoring of enrollees with ongoing medical conditions;

2-3.j.2(d) Identification of enrollees utilizing Emergency Department Services inappropriately to assist in scheduling follow-up care with Primary Care Physician and/or appropriate specialist to improve continuity of care and establish a medical home;

2-3.j.2(e) Coordinated hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;

2-3.j.2(f) Maintenance of its own internal tracking system which identifies the current preventive services screening status and pending preventive services screening due dates for each enrollee;

2-3.j.2(g) Authorization of out-of-plan or out-of-state services which are medically necessary due to an emergency;

2-3.j.2(h) Assistance in the coordination of mental health, medical care and other TennCare covered services of enrollees as described in Section 2-3.c. of this Agreement.

2-3.j.2(i) In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered 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 within or outside the CONTRACTOR's provider network. The CONTRACTOR must provide continuation of treatment through the lesser of the current period of active treatment, or for up to ninety (90) calendar days for members undergoing active treatment for a chronic or acute medical

condition. Continued access to the provider through the postpartum period must be provided for members in their second or third trimester of pregnancy. The CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost sharing due from the enrollee as payment in full for the service. If 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 T.C.A. Section 56-32-226 as described in Section 2-18 of this Agreement. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to a CONTRACTOR's enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed.

2-3.j.2(j) In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period.

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 within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

2-3.j.2 (k) The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement. For purposes of Sections 2-3.j.2(k) and (l), enrollees with special health care needs shall refer to enrollees identified through the Department of Children's Services (DCS), as described in Section 1-3 of this Agreement.

2-3.j.2 (l) The CONTRACTOR shall implement procedures to share, with other MCOs, BHOs, DBMs and PBMs (as necessary) serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.

2-3.j.3. Referrals and Exemptions

The CONTRACTOR shall require enrollees to seek a referral from their PCP or case manager prior to accessing non-emergency specialty services in accordance with the following provisions:

2-3.j.3(a) The CONTRACTOR shall exempt routine dental services for children under age 21 from case manager or PCP referral.

2-3.j.3(b) The CONTRACTOR shall allow an enrollee at least one (1) annual preventive care visit to a network obstetrician/gynecologist without obtaining a referral from a case manager or a primary care provider. Effective August 13, 2003, the CONTRACTOR shall allow female enrollees direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist. This requirement shall not be intended to extend benefits beyond an enrollee's available benefit limits.

2-3.j.3(c) The CONTRACTOR may exempt enrollees from case manager or PCP referral in order to obtain prenatal care from an obstetrician when the enrollee's PCP does not provide prenatal and delivery services. However, if the CONTRACTOR requires a referral in order to obtain prenatal care, the CONTRACTOR shall not require the enrollee to go for an office visit with their PCP in order to obtain the referral.

2-3.j.3(d) The CONTRACTOR may exempt routine vision services from case manager or PCP referral.

2-3.j.3(e) The CONTRACTOR shall provide all PCPs and Case Managers with a current listing of referral providers. MCOs who are entering an initial Agreement with TENNCARE and have never complied with this provision shall provide this initial listing to all PCPs and Case Managers within thirty (30) days of the effective date of this Agreement. A supplemental listing indicating additions and deletions shall be provided on a quarterly basis thereafter. Quarterly basis for purposes of mailing the supplemental listings shall be based on a calendar year schedule (e.g., Jan. – March, etc.). The electronic, web accessible, version shall be updated at least quarterly so as to accurately reflect current provider availability. A copy of the listing, a data file in a media and format described by TENNCARE and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed shall be sent 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.

2-3.j.3(f) Effective August 13, 2003, the CONTRACTOR must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee.

2-3.j.3(g) Effective August 13, 2003, for enrollees determined to need a course of treatment or regular care monitoring, the entity must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

2-3.j.4. Abusive Utilizers of Pharmacy Services

The CONTRACTOR shall send information to TENNCARE and the Office of Inspector General regarding lock-in candidates. Enrollees who disagree with such restrictions may appeal to TENNCARE pursuant to the medically necessary provisions of the TennCare hearing rules.

The TENNCARE PBM shall provide a monthly report to the CONTRACTOR listing all members identified for pharmacy lock-in. The CONTRACTOR shall use the report to identify enrollees requiring case management services as well as to notify the member's PCP and other appropriate health care providers.

2-3.j.5. Network Notice Requirements

All member notices required shall be written using the appropriate notice templates 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.

Failure to comply with notice requirements described herein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

2-3.j.5 (a) Enrollee Notification – Change in PCP

Written notice shall be given immediately to an enrollee by the CONTRACTOR when the CONTRACTOR changes the enrollee'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. The notice content shall be consistent with the notice template provided by TENNCARE.

2-3.j.5 (b) Enrollee Notification – Provider Termination

2-3.j.5(b)(1) Notice of PCP Termination

If a PCP ceases participation in the managed care organization (MCO), the MCO shall immediately provide written notice, no less than thirty (30) days prior to the effective date of the termination and no more than fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who has chosen the provider as their PCP. Each notice shall include all components identified in the notice template provided by TENNCARE. The requirement to provide notice thirty (30) 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) days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2-3.j.5(b) (2) Notice of Provider's Providing Ongoing Treatment Ceasing Participation

If an enrollee is in a prior authorized ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to

such enrollee and the MCO is aware of such ongoing course of treatment, the MCO shall immediately provide written notice within fifteen (15) calendar days from the date that the MCO becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template provided by TENNCARE. The CONTRACTOR must provide continuation of treatment through the lesser of the current period of active treatment, or for up to ninety (90) calendar days for members undergoing active treatment for a chronic or acute medical condition. Continued access to the provider through the postpartum period must be provided for members in their second or third trimester of pregnancy.

The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2-3.j.5(b) (3) Notice of Non-PCP Provider Termination

If a non-PCP ceases participation in the MCO, the CONTRACTOR shall immediately provide written notice to enrollees who have been patients of the non-PCP provider. Each notice shall include all components identified in the notice template provided by TENNCARE. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider termination when possible or immediately upon the CONTRACTOR becoming aware of the circumstances.

2-3.j.5.(c) Enrollee Notification –Network Deficiency

Upon final notification from TENNCARE of a network deficiency, which shall be based on the requirements of this Agreement and terms and conditions of the waiver (Attachment III), the CONTRACTOR shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the CONTRACTOR's network. The notice content shall be consistent with the notice template provided by TENNCARE.

2-3.j.5.(d) TENNCARE Notification – Provider Termination

2-3.j.5.(d)(1) Notice of Subcontractor Termination

When a subcontract that relates to the provision of services to enrollees or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) days prior written notice of the termination to TENNCARE and the TennCare Division, 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, as well as any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide TENNCARE with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.

2-3.j.5.(d)(2) Hospital Termination

Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the provider or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the Bureau of TennCare no less than thirty (30) calendar days prior to the effective date of the termination.

2-3.j.5.(d)(3) Other Provider Terminations

The CONTRACTOR shall notify TennCare of any provider termination and 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 2-3.j.5. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vender 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, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTOR's provider agreement with any primary care provider 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 2-3.b, such termination shall be reported by the CONTRACTOR in writing to the Bureau of TennCare, in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

2-3.k. Out of Area or Out of Plan Use

The CONTRACTOR shall notify and advise all enrollees of the provisions governing out of plan use, including the use of non-contract providers and the use of providers outside the community service area. The following criteria shall apply:

2-3.k.1. Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be in accordance with TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 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 timeframes for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A., Section 56-32-226, including but not limited to MCO reconsideration.

2-3.k.2. MCO Assignment Unknown – Services Obtained from Out-of-Plan Provider

The CONTRACTOR shall include provisions governing the payment for medically necessary covered services provided to an enrollee by a non-contract or non-referred provider for services received by an enrollee any time when TENNCARE determines that the enrollee is eligible for TennCare and has enrolled the individual in the CONTRACTOR's plan and the enrollee could not have known which MCO they were enrolled in at the time of the service. The parties to this Agreement recognize that in accordance with TennCare policies and procedures, if an enrollee requests enrollment in a specified MCO, the enrollee may be assigned 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 a community service area 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, etc. If an enrollee did not request enrollment in a specified MCO, the enrollee will be assigned to an MCO in accordance with TennCare policies and procedures. In either case, the effective date of enrollment may occur prior to the MCO being notified of the enrollee becoming a member of the plan. When this situation arises, the MCO shall not deny medically necessary services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, an MCO 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 MCO may impose timely filing requirements beginning on the date of notification of the individual's enrollment. When an enrollee has incurred medically necessary medical expenses that are covered benefits during a period of enrollment in the plan, the CONTRACTOR shall make reimbursement for the medical services and shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Failure to provide coverage of a service or make payments for a service within five (5) calendar days of a directive from TENNCARE shall result in the application of liquidated damages as described in Section 4-8 of this Agreement.

2-3.k.3. Medically Necessary Services obtained from Out of Plan Providers/Referred by Contract Provider

The CONTRACTOR shall include provisions governing the referral and payment for medically necessary services provided to an enrollee 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 plan if the enrollee had received the services from a provider who is participating in the CONTRACTOR's plan. The CONTRACTOR shall require the out-of-plan provider to accept the CONTRACTOR payment, plus applicable TennCare cost sharing responsibilities as payment in full for the service(s) as required by TennCare rules and regulations and Section 2-3.i of this Agreement.

2-3.k.4. Medically Necessary Services obtained from Out-of-Plan Providers/ Non-Referred

With the exception of circumstances described in Section 2-3.k.2 and 3, when an enrollee has utilized medically necessary non-emergency services available under the plan from a provider who was not enrolled as a participating provider in the CONTRACTOR's plan and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not pay for

the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

The CONTRACTOR shall not make payment to non-participating providers for services that are not medically necessary.

2-3.k.5. Services Ordered by Medicare Providers for Dual Eligibles

When a TennCare enrollee is dually eligible for Medicare and Medicaid and requires services that are covered by the plan but are not covered by Medicare, and the services are ordered by a Medicare provider who does not participate in the CONTRACTOR's plan, the CONTRACTOR must pay for the ordered service if it is provided by a contract provider. Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider. The CONTRACTOR shall not be liable for the cost of non-covered services or services which are not medically necessary or the cost of services ordered and obtained from non-contract providers.

In order to assure the TennCare/Medicare (dual population) enrollees assigned to TennCare MCOs continue to receive pharmacy services without interruption during the carve-out of their pharmacy benefits, each MCO is required to execute whatever measures are necessary with their subcontractor - pharmacy benefits manager (PBM) - so that a text message is sent to each dispensing pharmacy when a claim for a TennCare/Medicare enrollee is submitted to an MCO's PBM in error. The text message sent to the pharmacy must direct the pharmacy to submit the claim to the point-of-service, online pharmacy claims processor under contract to the TennCare Bureau to process pharmacy claims for TennCare/Medicare enrollees.

2-3.k.6. Credentialing of Non-Contract Providers

Credentialing Standards must apply to all licensed independent practitioners or groups of practitioners who have an independent relationship with the CONTRACTOR. An independent relationship is not synonymous with an independent contract.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

2-3.l. Advance Directives

The CONTRACTOR shall comply with federal requirements concerning advance directives such as a living will or a durable power of attorney for healthcare, as described in 42 CFR 422.128 and 489 Subpart I, and as described in T.C.A. Section 32-11-105, Sections 34-6-201 through 34-6-215, and Sections 68-11-201 through 68-11-224, and as stipulated by the enrollee.

2-3.m. Compliance with the Clinical Laboratory Improvement Act (CLIA) of 1988.

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires that all laboratory testing sites have either a CLIA certificate of waiver or a CLIA certificate of registration to legally perform testing in the United States.

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement must have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with

certificate 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.

2-3.n. Safety Net Providers

2-3.n.1. Federally Qualified Health Centers (FQHCs)

The CONTRACTOR is encouraged to contract for the provision of primary care services, preventive care services and/or specialty/referral services with Federally Qualified Health Clinics (FQHCs) and other safety net providers in the CONTRACTOR'S service area to the extent possible and practical. In addition, where FQHCs are not utilized, the MCO must demonstrate to the U.S. Department of Health and Human Services, the Tennessee Department of Human Services and to TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in a service area without contracting with FQHCs. If the CONTRACTOR utilizes FQHCs for services, the CONTRACTOR is required to address cost issues related to the scope of services provided by FQHCs and shall reimburse FQHCs either on a capitated (risk) basis considering adverse selection factors or reimburse FQHCs on a fee-for-service, cost-related basis.

In accordance with the HCFA Terms and Conditions to the TennCare Waiver, FQHC reporting information shall be submitted to TENNCARE on an annual basis as described in Section 2-10.k of this Agreement.

2-3.n.2. Local Health Departments

All MCOs participating in TennCare shall be required to contract with each Local Health Department for the provision of EPSDT services in the community service area(s) in which it is authorized to serve, until such time as the MCO achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Effective July 1, 2002, the CONTRACTOR shall reimburse the Local Health Department at no less than the following rates, unless specified otherwise by TENNCARE:

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

The CONTRACTOR agrees TENNCARE may conduct an audit of the MCO'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.

The provider agreement with the Local Health Department must meet the minimum requirements specified at Section 2-18 and must also specify for the purpose of EPSDT 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 2-9.m; (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 EPSDT services.

2-3.o. Coverage of Sterilizations, Abortions and Hysterectomies

The CONTRACTOR shall cover sterilizations, abortions and hysterectomies pursuant to applicable federal and state laws and regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the instructions with the original form maintained in the enrollee's medical file and a copy submitted to the CONTRACTOR for retention in the event of audit. Failure to follow applicable regulations and properly complete and maintain specific forms as required shall result in the application of sanctions as provided in Section 4-8 of this Agreement. The following are applicable current policies:

2-3.o.1. Sterilizations

2-3.o.1(a) Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

2-3.o.1(b) The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than 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.

2-3.o.1(c) The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.

2-3.o.1(d) The individual to be sterilized is mentally competent.

2-3.o.1(e) The individual to be sterilized 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.

2-3.o.1(f) The individual has voluntarily given informed consent on the approved "STERILIZATION CONSENT FORM" which is contained in this Agreement as Attachment V. 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.

2-3.o.2. Abortions

2-3.o.2(a) Abortion and services associated with the abortion procedure shall be covered 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.

2-3.o.2(b) A "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" form, contained in this Agreement as Attachment VI, must be completed.

2-3.o.3. Hysterectomy

2-3.o.3(a) Hysterectomy shall be covered when medically necessary.

2-3.o.3(b) The individual or her authorized representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.

2-3.o.3(c) The individual or her authorized representative, if any, must sign and date a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form, contained in this Agreement as Attachment VII, 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. See attached form and instructions for additional guidance and exceptions.

2-3.o.3(d) Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

2-3.o.3(e) Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

2-3.o.3(f) Hysterectomy shall not be covered if it was performed for the purpose of cancer prophylaxis.

2-3.p. Coverage of Organ and Tissue Transplants

The CONTRACTOR shall cover non-investigational/experimental organ and tissue transplants, as covered by Medicare, when medically necessary and consistent with the accepted mode of treatment for which the transplant procedure is performed. Besides the minimally required transplants, the CONTRACTOR may cover other transplants that are not considered investigational or experimental by the National Institutes of Health, if approved by TENNCARE. For purposes of this Section, investigational or experimental shall mean those transplants and/or procedures which are not considered medically necessary and which have not been approved by the Centers for Medicare and Medicaid Services and published in the Federal Register. Questions as to whether a particular transplant and/or procedure is to be covered shall be directed to the Chief Medical Officer, Bureau of TENNCARE.

Exceptions to the above list of transplants must be made for other non-investigational/non-experimental transplants if the transplant and/or procedure is found to be medically necessary, performed within the accepted mode of treatment for which it is intended, and is found to be cost effective as determined by the CONTRACTOR.

The CONTRACTOR shall establish its own administrative procedures regarding the necessity of prior approval before a transplant procedure is performed. The CONTRACTOR shall also establish its own administrative procedures regarding the coverage of transplant procedures performed outside the CONTRACTOR's service area as well as transplant procedures performed out-of-state. Until January 1, 2003, the CONTRACTOR shall utilize its transplant policies and procedures that were in effect as of April 16, 2002, unless otherwise authorized by TENNCARE.

Section 1862 of the Social Security Act requires Medicare beneficiaries to have transplants performed in Medicare certified centers. In accordance with this policy, the CONTRACTOR and Medicare/Medicaid dually eligible enrollees shall be required to adhere to these requirements.

2-3.q. Use of a Drug Formulary

The CONTRACTOR shall be required to cover pharmacy services as a benefit pursuant to this Agreement and the TennCare rules and regulations for those eligible populations as described by TENNCARE. This coverage may be accomplished by the use of an open formulary (whereby all drugs are covered) or by use of a closed formulary (whereby only designated drugs are covered). If coverage is pursuant to a closed formulary, the formulary and any subsequent additions or deletions to the formulary, must be prior approved by the TENNCARE Pharmacy Director. Approval of a closed formulary will not be granted if it is determined that the formulary is too restrictive or fails to provide for medically necessary drugs. Formularies, whether open or closed, shall not include DESI, LTE or IRS drugs. Approval or disapproval of formularies and subsequent additions and deletions thereto shall be made in accordance with TennCare policy and procedures. The CONTRACTOR shall adhere to the following provisions:

2-3.q. 1. When medically necessary TennCare covered pharmacy benefits have been received during a period that an enrollee or provider could not have reasonably known what MCO the enrollee was in, the MCO shall not deny medically necessary pharmacy benefits for lack of prior authorization or as non-covered benefits when the medically necessary pharmacy benefits would be considered TennCare covered benefits except for the fact that they are not included on the CONTRACTOR’s closed drug formulary.

2-3.q. 2. If coverage is pursuant to a closed formulary, an up-to-date copy of the complete formulary and a complete description of prior authorization criteria for each drug requiring prior authorization must be submitted via an electronic file to the TennCare Pharmacy Director in a format specified by the TennCare Pharmacy Director by January 1 of each year. TENNCARE shall provide the format for this file no later than November 1 of each year.

2-3.q. 3. Authorization of drugs, including prior approvals of formulary drugs and medical necessity reviews of non-formulary drugs, or denial of authorization of drugs shall be rendered by the CONTRACTOR or its subcontractor on the day of the formal request for authorization. If a CONTRACTOR or its subcontractor is unable to respond to a prior approval or medical necessity review request on the day of the request or if the prescriber is unavailable, the CONTRACTOR must provide a two (2) week supply of the prescribed medication, provided that:

2-3.q.3.(a) The medication is not classified by the Food and Drug Administration as Less Than Effective (i.e., a DESI, LTE or IRS drug), or

2-3.q.3.(b) The medication is not a drug in a non-covered TENNCARE therapeutic category (e.g., appetite suppressants, drugs to treat infertility), or

2-3.q.3.(c) Use of the medication is not contraindicated because of the patient's medical condition or possible adverse drug interaction, or

2-3.q.3.(d) If the patient is not already taking the medication, use of the medication for a two (2) week period possibly followed by abrupt discontinuance of the drug would not be medically contraindicated, or

2-3.q.3.(e) The prescriber did not prescribe a total quantity less than a two (2) week supply, in which case the pharmacist must provide a supply up to the amount prescribed, or

2-3.q.3.(f) Provision of the two (2) week supply would not violate state or federal Controlled Substances laws.

In some circumstances it is not feasible for the pharmacist to dispense a two (2) week supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging. Examples would include but not be limited to inhalers, eye drops, ear drops, injections, topicals (creams, ointments, sprays), drugs packaged in special dispensers (birth control pills; steroid dose packs), and drugs that require reconstitution before dispensing (antibiotic powder for oral suspension). When a coverage of a two (2) week supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense a two (2) week supply, it shall be the responsibility of the MCO to provide coverage for the amount prescribed.

Failure to provide a two (2) week supply of the prescribed medication as described above shall result in liquidated damages as described in Section 4-8. of this Agreement.

2-3.q. 4. Comply with the requirements of the TennCare Drug Formulary Accountability Act.

2-3.q. 5. MCOs shall not deny or withhold payment to any pharmacy for duplicate prescription refills, or prescriptions that are filled early in relation to the prior day's supply dispensed, where such refills are for the purpose of replacing an enrollee's lost or destroyed medication or providing an enrollee with the quantity of medication necessary for extended travel away from the community in which the enrollee resides, or for any other bona fide reason that causes the enrollee to be without a medication, when the discontinuation of the medicine would, in the pharmacist's professional judgment, place the enrollee at risk of harm. Provision of such duplicate prescription refills or early refills shall comply with applicable state and federal Controlled Substances laws and other state pharmacy laws and regulations.

2-3.q. 6. MCOs that impose a limit on the number of units of a medication that an enrollee can obtain per month without a medical necessity override shall have policies and procedures that permit the prescribing physician to request a medical necessity override upon submission of medical justification and that also permit a pharmacist to request an override to allow early dispensing, when in the pharmacist's professional judgment, the

enrollee is not abusing the medication and needs early dispensing of the medication due to lack of readily accessible transportation.

2-3.q. 7. The CONTRACTOR agrees all pharmacy rebates received by the CONTRACTOR shall be treated as offsets to medical expenses.

Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.

2-3.r. Prenatal Care

The CONTRACTOR shall have policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care. This provision shall apply to enrollees in the plan who become pregnant as well as enrollees who are pregnant on the beginning date of enrollment in the plan. This provision does not intend to require all of the CONTRACTOR's network providers to accept new enrollees. However, the CONTRACTOR shall maintain a provider network consisting of providers who accept new enrollees in accordance with TennCare access standards and shall inform TENNCARE, as required, of network providers who do not accept new enrollees. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care 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 within or outside the CONTRACTOR's provider network. In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

MCOs participating in TennCare are required to provide or arrange for the provision of medically necessary medical care to their enrollees beginning on the date of their enrollment in the MCO's plan. This requirement includes not only TennCare enrollees whose eligibility is established through SSI, Medicaid or uninsured/uninsurable applications for TennCare, but also those pregnant women who establish "presumptive eligibility" for TennCare. Effective with the first day of a presumptive eligibility period, the State makes fixed administrative fee payments on behalf of these women to the selected MCO and the MCO is required to provide or arrange for the provision of medical care for their enrollee during this period.

Women who are presumptively eligible are entitled to all TennCare benefits. There shall be a sufficient number of providers in the MCO's network who accept enrollees within each geographical location in which the plan is marketed so that prenatal or other medically necessary medical care is not delayed or denied to these women during their presumptive eligibility period. Additionally, the MCO must make services available out-of-plan, if necessary, to meet the medical needs of a woman enrolled in the MCO's plan as a presumptive eligible.

The CONTRACTOR shall notify all network providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the network provider's contract with the CONTRACTOR. Delay in care for pregnant enrollees shall mean:

2-3.r. 1. Failure of the MCO to respond to an enrollee's request for prenatal care by identifying a maternity care provider to honor a request from an enrollee, including a presumptive eligible enrollee, (or from a primary care provider or patient advocate acting on behalf on an enrollee) for a prenatal care appointment. Accessibility shall be in accordance with the Terms and Conditions for Access to the TennCare Waiver and contained herein as Attachment III unless TENNCARE shall specify more stringent access criteria. Regardless of whether prenatal care is provided by a primary care physician, physician extender or an obstetrician who is not the enrollee's primary care physician, the access standards for primary care physician or extender 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 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) days of the day they are determined to be eligible; or

2-3.r. 2. Failure of a pharmacist within the MCO's provider network to fill a prescription written by a maternity care provider for an enrollee, including an approved presumptive eligible, within the specified time frames for all medically necessary requests as described elsewhere in this Agreement and/or the TennCare rules and regulations. Effective July 1, 2003, pharmacy services, as described in 2-3.a shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.

Failure to provide prenatal care in accordance with the provisions described herein shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16, and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 4-8 of this Agreement.

2-3.s. Utilization Management

The CONTRACTOR shall develop and maintain a Utilization Management Program Description defining the structures and processes within the CONTRACTOR's utilization management program. The program description shall assign responsibility to appropriate individuals including a designated senior physician. The Utilization Management Program shall be supported by an associated work plan. The program shall be evaluated annually. The Utilization Management Program Description, Annual Evaluation, and Work Plan shall be approved by the appropriate oversight committee within the health plan and be submitted to TENNCARE for approval by April 15th of each year. Analysis of findings and actions taken should be included in the Annual Evaluation.

The CONTRACTOR shall assess provider/office staff satisfaction with the prior authorization (PA) process to identify areas that can be improved. Survey shall be conducted at least annually and report shall be submitted to TennCare by June 15th. The CONTRACTOR shall take strong action to address opportunities for improvement identified from information gathered about satisfaction with the PA process.

The CONTRACTOR shall not place arbitrary maximum limits on the length of stay for enrollees 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 TennCare enrollee and his/her medical history. Individual patient characteristics must be considered in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to place "tentative" limits on the length of a prior authorization or pre-certification.

1. Inpatient Care. 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 Utilization Management policies and procedures in effect April 16, 2002 and, at a minimum, shall include the items specified in subparagraphs (a) through (e) below. In the event said policies and procedures do not include these minimum components, the CONTRACTOR shall develop policies and procedures, if requested by TENNCARE. The CONTRACTOR shall develop policies and procedures within thirty (30) calendar days of receipt of written request and shall agree to implement said policies and procedures within sixty (60) days or receipt of written approval from TENNCARE:

   (a) Pre-admission certification upon notification for all non-emergency admissions;

   (b) A concurrent review program to monitor and review continued inpatient hospitalization (for hospitals that are not reimbursed on a DRG basis), length of stay (for hospitals that are not reimbursed on a DRG basis), 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 patient can be transferred to a network facility, if presently in a non-network facility. Concurrent hospitalization review should occur in 95% of the cases where applicable at the two most frequently utilized hospitals;

   (c) 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 (for hospitals that are not reimbursed on a DRG basis and for outlier DRG cases) 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;

   (d) Pre-admission certification should not be employed for admissions for the normal delivery of children; and

   (e) Prospective review procedures may also include pre-admission testing criteria and criteria for same day surgery procedures.

2. MCO Case Management

   (a) The CONTRACTOR shall maintain an MCO case management program that includes the following components:

      (1) A systematic approach to identify eligible members;
      (2) Assessment of member needs;
      (3) Development of an individualized plan of care;
      (4) Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
      (5) Program Evaluation.

   (b) 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:

(1) Members who have reached the service threshold for inpatient hospital services;

(2) Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions;

(3) Members who meet the requirements at 2-3.s.5(a) regarding excessive and/or inappropriate Emergency Department Utilization; and

(4) Children with special health care needs unless already enrolled in an appropriate disease management program.

(c) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program.

(d) Eligible members must be offered MCO case management services. However, member participation shall be voluntary.

(e) 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.

(f) The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM 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.

(g) The CONTRACTOR shall submit a quarterly case management report 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 services.

(h) By August 15, 2007, the CONTRACTOR will submit a report to TENNCARE describing the CONTRACTOR's case management services. The report will 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.

3. Transition of Care. The CONTRACTOR will actively assist members with chronic or acute medical conditions in transitioning to another provider when the current provider has terminated participation with the CONTRACTOR. The CONTRACTOR will allow continuation of treatment through the lesser of the current period of active treatment, or for up to ninety (90) calendar days for members undergoing active treatment for chronic or acute medical conditions. The CONTRACTOR will allow continued access to the provider through the postpartum period for enrollees in their second or third trimester of pregnancy.

4. Discharge Planning. The CONTRACTOR shall maintain and operate a formalized discharge planning program.

5. Excessive and/or Inappropriate Emergency Department (ED) Utilization. The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

(a) Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March. A report shall be submitted to TENNCARE no later than February 28th and August 31st each year identifying enrollees who exceeded the defined threshold for ED usage and specifying the interventions initiated for each enrollee.

(b) Enroll in active case management – (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)

(c) Make contact with enrollee and primary care provider

(d) Review encounter data

(e) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)

(f) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:

(1) Drug seeking behavior

i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement

ii. Contact all providers regarding concern that patient may be abusing prescription medications

iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)

iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)

(2) Primary Care /Access Problem

i. Change PCP and/or address problem with current PCP

ii. Provide enrollee education regarding appropriate use of PCP and ED

iii. Provide access to a 1-800 customer service line for assistance identifying and selecting a PCP and to the extent necessary, assistance scheduling an appointment with PCP

(3) Poorly controlled disease

i. Enroll in disease management

ii. Refer to specialist for management – advise PCP

iii. Provide access to 1-800 24/7 nurse answered line capable of providing health information/education to patients; healthcare counseling/telephone triage to assess health status to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings.

(g) Any blanket policy to deny payment for specified "non-emergency" services in the ED based on diagnoses must be accompanied by the following guidelines.

(1) Clear communication to all hospitals/EDs regarding the diagnoses that are and are not considered emergencies;

(2) A process whereby the hospital could demonstrate that a condition on the list did, in fact, represent an emergency;

(3) Clear communication to all hospitals/EDs regarding the mechanism to bill for the EMTALA required screen associated with any non-emergency diagnoses;

(4) Payment for the EMTALA screens associated with any non-emergency diagnosis, and

(5) A specific process that the MCO shares with all hospitals/EDs by which the ED can contact the MCO 24/7 to refer an enrollee with one of the non-emergency diagnoses to the MCO for assistance in arranging for care in an alternative setting, when such assistance is requested by the member.

(h) For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the MCO must have a specific process in place whereby the ED can contact the MCO 24/7 via a toll free phone line to obtain assistance for enrollees 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 at Section 2-9.c.8 of this Agreement for this purpose or may use another line the CONTRACTOR designates. By August 1, 2007, the CONTRACTOR must submit a written report to TENNCARE providing the telephone number that will be used for such scheduling assistance 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.

(i) If the CONTRACTOR chooses to implement a blanket policy as identified in subsection (g) above, failure to comply with the ED guidelines as described therein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

(j) The CONTRACTOR shall track and report on a quarterly basis, 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 enrollee, 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 2-9.c.8 of this Agreement.

6. Disease Management. Each MCO is required to establish and operate (either directly or via a subcontract with a disease management vendor) a minimum of four disease management (DM) programs designed to address maternity care management, comprehensive diabetes management, management of congestive heart failure and management of asthma.

Each DM program must utilize evidence-based best practice guidelines and patient empowerment strategies to support the practitioner-patient relationship and the plan of care. The programs must emphasize prevention of exacerbation and complications as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

(a) DM Program Policies and Procedures

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:

(1) Definition of the target population;
(2) Member identification strategies;
(3) Program content including, but not limited to:
    (a) Evidence-based best practice guidelines upon which the program is based;
    (b) Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
    (c) Methods for informing and educating members;
    (d) Methods for informing and educating providers; and
(4) Program evaluation.

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.

(b) **Member Identification Strategies**

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

(1) Members who have reached the service threshold for inpatient hospital services (see Section 2-3.a.2).
(2) Members who meet the requirements at 2-3.s.5(f)(3) regarding excessive and/or inappropriate Emergency Department Utilization who could potentially benefit from enrollment in a disease management program.
(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.

The MCO must operate each program using an “opt out” methodology, meaning that services will be provided to eligible members unless they specifically ask to be excluded. The Bureau may elect to mandate the eligibility criteria the MCO must use if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the criteria in use are overly restrictive.

(c) Program Content

The MCO must adopt clinical practice guidelines that serve as the basis for each DM program. The guidelines must be evidence-based and formally adopted by the QI or other clinical committee. The guidelines must be distributed to practitioners who are likely to use them and must be made available to the Bureau upon request. Upon enrollment in the DM program, the MCO must provide information to the member and practitioner regarding how to use the services and specific information to the practitioner concerning how the program

works with the practitioner's patients. MCOs must provide primary care providers with a list of their patients enrolled in each program upon initial enrollment and at least annually thereafter.

Each DM program must be based on a treatment plan that serves as the outline for all of the activities/interventions in the program. At a minimum the activities/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. The Bureau may elect to mandate an intervention strategy the MCO must employ if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the interventions are suboptimal.

(d) 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.

(e) CONTRACTOR's Program Description

The CONTRACTOR shall submit a description of it's Disease Management Program on an annual basis in accordance with Section 2-10.m.7(b).

(f) **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:

(1) Are proactive and effective partners in their care;
(2) Understand the appropriate use of resources needed for their care;
(3) Identify precipitating factors and appropriate responses before they require more acute intervention; and
(4) Are compliant and cooperative with the recommended treatment plan.

(g) **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.

(h) Program Evaluation (Satisfaction and Effectiveness)

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. A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.

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 the following information. This information shall be reported to TENNCARE annually on July 1st in accordance with Section 2-10.m.7.

1. The total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required DM programs;
2. The passive participation rate (as defined by NCQA) for each of the required DM programs, including the numerator and denominator used in calculating the rate
3. The number of individuals participating in each level or stratification of each of the DM programs;
4. Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
5. The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
6. Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
7. HEDIS measures related to any of the four DM projects;
8. Member adherence to treatment plans;
9. Provider adherence to the guidelines; and
10. Any other performance measure associated with any of the four DM programs that the MCO has chosen to track.

7. Disease Management for Obesity. In addition to the aforementioned disease management requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2-3.h). 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 2-9.m.

8. Hospitalizations and Surgeries. The CONTRACTOR must comply with any applicable 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 or the EQRO may conduct special studies to assess the appropriateness of hospital discharges.

9. Compensation for Utilization Management Activities. CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), and 42 CFR 422.208, 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).

2-3.t. Availability and Accessibility of Emergency Medical Services

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. The CONTRACTOR shall provide coverage for inpatient and outpatient services, furnished by a qualified provider, regardless of whether the enrollee obtains the services from a network provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard without prior authorization in accordance with 42 C.F.R. § 422.113. Once the individual's condition is stabilized, the CONTRACTOR may require authorization for hospital admission or follow-up care. The CONTRACTOR shall base coverage decisions for emergency medical services on the severity of the symptoms at the time of presentation and shall cover emergency medical 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 impose no restrictions on coverage of emergency medical services more restrictive than those permitted by the prudent layperson standard.

If an emergency screening examination leads to a clinical determination by the examining physician 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 patient. The CONTRACTOR shall be required to pay for all emergency medical services which are medically necessary until the clinical emergency is stabilized. This includes all medical services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If there is a disagreement between the hospital and the CONTRACTOR concerning whether the patient 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 physician(s) actually caring for the patient 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 physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient, provided that such arrangement does not delay the provision of emergency medical services.

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 physician that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the patient had acute symptoms of sufficient severity at the time of presentation. In such cases, the CONTRACTOR shall review the presenting symptoms of the patient 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.

When the patient's primary care provider instructs the patient to seek emergency care, the CONTRACTOR shall be responsible for payment for the medical screening examination and for other medically necessary emergency medical services, without regard to whether the patient meets the prudent layperson standard.

2-3.u. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education. The CONTRACTOR must assure the availability and accessibility of required health care resources and help enrollees and their parents or guardians use these resources effectively. The State EPSDT program shall be referred to as "TENNderCare". The CONTRACTOR shall use "TENNderCare" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENNderCare as of July 1, 2004.

The CONTRACTOR shall provide EPSDT services to enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. EPSDT Services means early and periodic screening, diagnosis and treatment of enrollees under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B 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, whether or not such services are covered under the state plan. 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). The CONTRACTOR shall be responsible for the provision of all related services except for behavioral health services that are carved out as a separate arrangement from this Agreement as well as Pharmacy and Dental services at such time as they are removed from the responsibilities described in this Agreement. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

2-3.u.1 In accordance with TennCare requirements and pursuant to 42 USC §1396d(r), Early and periodic screening, diagnostic, and treatment (EPSDT) services shall at a minimum include:

(a) Screening services provided at intervals:

(1) which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care

(2) indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions and

(b) Services which, at a minimum, include

(1) comprehensive health and developmental history (including assessment of both physical and mental health development and dietary practices);

(2) a comprehensive unclothed physical exam (the child's growth shall be compared against that considered normal for the child's age and gender);

(3) appropriate immunizations schedule according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history. The ACIP Recommendations on Immunization Practices are approved by the American Academy of Pediatrics.

(4) 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 12 and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening lead blood 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 10 ug/dl obtained by capillary specimen (finger stick) must be confirmed by using a venous blood sample.

(5) health education includes anticipatory guidance based on the findings of the physical and/or dental screening. Health education should include counseling to both parents (guardians) and children 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.

(6) Vision services

(i) which are provided at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care and
(ii) which at a minimum include diagnosis and treatment for defects in vision, including eyeglasses

(7) Dental services which are provided

(i) at intervals which meet reasonable standards of dental practice as determined by the state after consultation with recognized dental organizations involved in child health care and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition
(iii) and which shall at a minimum include relief of pain and infections, restoration of teeth and maintenance of dental health

(8) Hearing services which are provided

(i) at intervals which meet reasonable standards of medical practice as determined by the state after consultation with recognized medical organizations involved in child health care and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition and
(iii) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(9) Transportation assistance for a child 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. Blanket restrictions may not be imposed 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.

The requirement to provide the cost of meals shall not be interpreted to mean that an enrollee and/or an attendant can request meals while in transport to and from care. Rather, this provision is intended for use when an enrollee has to be transported to a major health facility for services and care cannot be completed in one day thereby requiring an overnight stay.

The CONTRACTOR shall offer transportation and scheduling assistance to all children under age 21 referred for an assessment who do not have access to transportation. This may be accomplished through various means of communication to enrollees, including but not limited to, member handbooks, EPSDT outreach notifications, etc.

An EPSDT enrollee may be considered for transportation if such enrollee has written permission from the treating physician and custodial parent(s). Circumstances that may permit the CONTRACTOR and/or its transportation vendor to refuse the transportation request would be as follows:

(i) The EPSDT enrollee is under the age of eighteen (18) and does not have an attendant.

(ii) The EPSDT enrollee has an attendant, but the attendant is not a parent or legal guardian and cannot legally sign for the enrollee to receive medical care, i.e., the EPSDT enrollee may be a foster or stepchild. Some foster or stepparents do not have legal authority to sign for medical care for foster or step children. The CONTRACTOR and transportation vendors must be aware of this and must ask these questions when scheduling transport.

(iii) The enrollee or attendant according to a reasonable person's standards has to be noticeably indisposed [disorderly conduct, intoxicated, armed (firearms), possession of illegal drugs, knives and/or other weapons], and in any other condition that may affect the safety of the driver or persons being transported.

(10) Follow up for elevated blood lead levels in children must be carried out in accordance with the State Medicaid Manual, Part 5 (http://www.hcfa.gov/pubforms/pub45/pub_45.htm). The Manual currently says that children with blood lead levels equal to or greater than 10ug/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.

In accordance with the State Medicaid Directors' letter issued by CMS (formerly HCFA) on October 22, 1999, MCOs are responsible 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 case management services and the one-time investigation to determine the source of lead."

The MCO is responsible for the primary environmental lead investigation for children when elevated blood levels suggest a need for such an investigation. This investigation, which is commonly called a "lead inspection," involves the use of x-ray fluorescence (XRF) machines in the home which have the ability to identify lead-based paint.

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 MCO is not responsible for either the "risk assessments" or the lead inspection at the secondary site. The Department of Health (TDH) should be contacted when these services are indicated. TDH has a federal grant which can be used to purchase such services when either or both are deemed necessary by health department staff, as long as funds are available. The assessments are done by certified inspectors in the Department of Environment and Conservation (TDEC).

MCO 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.

(11) Such other necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) to correct, 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 State plan.

2-3.u.2 42 CFR 441.56(b) defines “screening” as “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.” At a minimum, screenings must include, but are not limited to:

(a) Comprehensive health and developmental history;
(b) Comprehensive unclothed physical examination;
(c) Appropriate Immunizations;
(d) Appropriate vision and hearing testing;
(e) Appropriate laboratory tests; and
(f) Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
(g) Health Education.

At a minimum, these screening services shall include periodic and interperiodic screens and must be provided in accordance with "reasonable standards of medical and dental practice" as determined by the State. 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. Pursuant to Section 2-3.a.3, "screens shall be in accordance with the periodicity schedule set forth in the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care' and all components of the screens must be consistent with the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and the American Academy of Pediatric Dentistry (AAPD) guidelines. The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. 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 an in-network provider.

2-3.u.3 Should screenings indicate a need, the following services must be provided, even if the services are not included in the State plan:

(a) Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
(b) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and
(c) Appropriate immunizations.
(d) Such other necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

2-3.u.4 The CONTRACTOR shall comply with all requirements described in this Agreement regarding EPSDT, including but not limited to:

(a) Screening rate requirements/Local Health Department Contracts as described in Sections 2-3.n.2 and 2-9.j.5;
(b) Reporting, including but not limited to, Quarterly EPSDT reports; and
(c) The "EPSDT Screening Guidelines" as described herein this Section 2-3.u and Attachments VIII of this Agreement.

2-3.u.5 The CONTRACTOR shall have policies and procedures in place, approved by TENNCARE, to require providers to refer enrollees for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate, or prevent from worsening defects, and mental illnesses and conditions discovered by the screening service, regardless of whether the required services is covered by the enrollee's BHO or MCO, and to document said referrals in the enrollee's medical record.

2-3.u.6 The CONTRACTOR shall direct its network providers to notify the MCO in the event a screening reveals the need for other health care and the provider is unable to make an appropriate referral for those services. Upon notification of the failed referral, the CONTRACTOR shall secure an appropriate referral and contact the enrollee to offer

scheduling assistance and transportation for enrollees lacking access to transportation. If the needed health care is a BHO benefit, the CONTRACTOR shall contact the enrollee's BHO and inform them of the need to contact the enrollee to secure an appropriate referral and offer scheduling assistance and transportation. The CONTRACTOR shall maintain documentation of said contacts. In the event of a dispute regarding the organization responsible for the provision of the services, the CONTRACTOR shall adhere to the requirements specified in Section 2-3.c.2.

2-3.u.7 The CONTRACTOR shall be responsible for various outreach activities and for informing enrollees assigned to its plan who are under the age of 21, or their parent or guardian, of the availability of early and periodic screening, diagnostic, and treatment services. All Enrollee material shall be submitted to TENNCARE for approval prior to distribution and shall be made available in accordance with the requirements specified in Section 2-5. In order to comply with this requirement, the CONTRACTOR shall, at a minimum, adhere to the following:

(a) The CONTRACTOR must have a process in place to distribute to each member a minimum of six (6) "outreach contacts" a year from the MCO with information about EPSDT. The "outreach contacts" include: 1 member handbook, 4 newsletters, 1 reminder before a screening is due.

1. Information included in the member handbook regarding EPSDT services must be sent within thirty (30) days of receipt of notification of enrollment as specified in Section 2-5.b.1 and 2-6.b.1. Annually thereafter, upon the Enrollee's anniversary date of enrollment, the CONTRACTOR shall send an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services. All handbooks must be in accordance with the TennCare Marketing Guidelines and Section 2-5 of this Agreement.
2. Each quarterly newsletter, as described in Section 2-5.b.2 shall include EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.
3. The MCO must have a mechanism for notifying families when EPSDT screens are due. This mechanism must include an offer of transportation and scheduling assistance.
4. MCOs must have the ability to conduct EPSDT outreach in formats appropriate to enrollees who are blind, deaf, illiterate or non-English speaking. At least one of the 6 outreach attempts identified above must advise enrollees 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.

(b) The CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. The MCO must have a mechanism for maintaining records of efforts made to reach out to children who have missed screening appointments or who have failed to receive regular check-ups. The MCO must make at least one effort each quarter to get such children in for a screening. These efforts are in addition to the efforts described in Section 2-3.u.7 (a) above and must be a different written or oral strategy each quarter. It will not be adequate to simply send the same letter four times.

(c) The MCO must have a process for determining if someone eligible for EPSDT has used no services within a year. The MCO must make two reasonable

attempts to re-notify such members about EPSDT. One of these attempts can be to refer the member/family to the local health department for a screen. (These two attempts are in addition to the one attempt per quarter mentioned above.)

(d) The MCO shall require that providers have a process for documenting services declined by a parent or guardian or mature competent child, specifying the particular service was declined. This process must meet all requirements outlined in the State Medicaid Manual, Part 5, Section 5320A, concerning declination of EPSDT services.

(e) The MCO must make and document a minimum of two (2) reasonable attempts to find a family when mail is returned as undeliverable. At least one of these attempts must be oral.

(f) The MCO must make available to families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare as described in Section 2-6.b.1(b) of this Agreement.

(g) The MCO must target specific informing activities to pregnant women and families with newborns. Pregnant women must be informed prior to the enrollee's delivery date about the availability of EPSDT for their children, provided that the MCO is informed of the pregnancy, and must be offered EPSDT services for the child when it is born.

(h) Pregnant women who are determined presumptively eligible must receive assistance in making a timely prenatal appointment as soon as the MCO is aware of the presumptive eligibility. For a woman past her first trimester, the appointment should occur within 15 days in accordance with 2-3.r.

2-3.u.8 The services listed in the Social Security Act, Section 1905(a), and the entity responsible for providing them under TennCare, are listed below. All services, other than EPSDT screens and interperiodic screens, must be medically necessary in order to qualify for TennCare coverage. Services may be required to be provided by network provider. All services provided by non-participating providers may require prior approval by the MCO.

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	MCO	MCOs are not required to contract with Rural Health Clinics if the services are available through other providers in their networks.
(2)(C) Federally-qualified health center services	MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
		them.
(3) Other laboratory and X-ray services	MCO, except that the BHO is responsible for laboratory services relating to BHO drugs	
(4)(A) Nursing facility services for individuals age 21 and older		Not applicable for EPSDT
(4)(B) EPSDT services	MCO for physical health services, except as described in Section 2-3.c.2 and 3; BHO for mental health and substance abuse services, except as described in Section 2-3.c.2; Effective October 1, 2002, DBM for dental services except as described in Section 2-3.c.3; Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	
(4)(C)--Family planning services and supplies	MCO; Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	
(5)(A)--Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility	MCO for physical health services, except as described in Section 2-3.c.2; BHO for mental health and substance abuse services, except as described in Section 2-3.c.2	
(5)(B)—Medical and surgical services furnished by a dentist	MCO; Effective October 1, 2002, DBM except as described in Section 2-3.c.3	
(6)—Medical care, or any other type of remedial care	MCO for physical health services;	See Item (13).

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law	BHO for mental health and substance abuse services	
(7)—Home health care services	MCO for physical health services; BHO for mental health and substance abuse services	
(8)—Private duty nursing services	MCO for physical health services; BHO for mental health and substance abuse services	
(9)—Clinic services	MCO for physical health services; BHO for mental health and substance abuse services	
(10)—Dental services	MCO; Effective October 1, 2002, DBM except as described in Section 2-3.c.3	
(11)—Physical therapy and related services	MCO	
(12)—Prescribed drugs, dentures, and prosthetic devices, and eyeglasses	MCO for physical health services; TennCare PBM for mental health and substance abuse drugs Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1 MCO for dentures until October 1, 2002, DBM for dentures thereafter	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed	MCO for physical health services; BHO for mental health and substance abuse services Effective October 1, 2002, DBM for	The following are considered practitioners of the healing arts in Tennessee law [1]: • Alcohol and drug abuse counselor • Athletic trainer • Audiologist

[1] This list has been provided by the Tennessee Department of Health.

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
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	dental services as described in Section 2-3.a.1 and 2-3.c.3 Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	• 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 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

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
		• 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 • 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 EPSDT
(15) Services in an intermediate care facility for the mentally retarded	TennCare	
(16) Inpatient psychiatric services for individuals under age 21	BHO	
(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 providers in their networks.
(18) Hospice care	MCO	
(19) Case management services	MCO for physical health services; BHO for mental health and substance abuse services	
(20) Respiratory care services	MCO	
(21) Services furnished by	MCO	The MCOs are not required to

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
a certified pediatric nurse practitioner or certified family nurse practitioner		contract with PNPs or CFNPs if the services are available through other providers in their networks.
(22) Home and community care for functionally disabled elderly individuals		Not applicable for EPSDT
(23) Community supported living arrangements services		Not applicable for EPSDT
(24) Personal care services	MCO for physical health services; BHO for mental health and substance abuse services	
(25) Primary care case management services	MCO	
(26) Services furnished under a PACE program		Not applicable for EPSDT
(27) Any other medical care, and any other type of remedial care recognized under State law.	MCO for physical health services; BHO for mental health and substance abuse services Effective October 1, 2002, DBM for dental services as described in Section 2-3.a.1 and 2-3.c.3 Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	See Item (13).

Note 1: "Targeted case management services," which are listed under section 1915(g)(1), are **not EPSDT services** except to the extent that the definition in section 1915(g)(2) is used with Item (19) above. DCS provides targeted case management services to children in custody and at risk of custody.

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 21, in an inpatient setting." Psychiatric residential treatment facility services are furnished by DCS to children in custody but are otherwise the responsibility of the BHO.

Note 3: "Rehabilitative" services are differentiated from "habilitative" services in federal law. "Rehabilitative" services, which are EPSDT 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 EPSDT 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."

Note 4: Certain services are covered under a Home and Community Based Waiver but are **not EPSDT services** because they are not listed in the Social Security Act section 1905(a). These services include habilitation, prevocational, and supported employment services; homemaker services; and respite services. (See section 1915(c)(4).)

Note 5: Certain services are not coverable even under a Home and Community Based Waiver and are **not EPSDT 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).)

2-3.v Notice of Action to Enrollees

The CONTRACTOR shall comply with all enrollee notice requirements described in TennCare Rules 1200-13-13-.11 and 1200-13-14-.11.

2-3.w Compliance with Health Insurance Portability and Accountability Act (HIPAA) Requirements

2-3.w.1 In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum, comply with the following requirements:

(a) As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity under the HIPAA regulations;

(b) The CONTRACTOR shall comply with the transactions and code set, privacy, and security regulations, once finalized, of the Health Insurance Portability and Accountability Act of 1996 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.

(c) The CONTRACTOR shall transmit/receive from/to its provider, 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;

(d) The CONTRACTOR shall 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 4-2;

(e) Protected Health Information (PHI) data exchanged between the CONTRACTOR and TENNCARE is intended to be used only for the purposes of health care operations, payment and oversight and its related functions. All PHI data not transmitted for the purposes of health care operations and its related functions, or for purposes allowed under the federal HIPAA regulations will be de-identified to protect the individual enrollee's PHI under the privacy act;

(f) Disclosures of Protected Health Information from the CONTRACTOR to TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: health care operation, payment and oversight, obtaining premium bids for providing health coverage, modifying, amending or terminating the group health plan. Disclosures to TENNCARE from the CONTRACTOR shall be as permitted and/or required under the law.

(g) The CONTRACTOR shall report to TENNCARE within five (5) days of becoming aware of any use or disclosure of Protected Health Information 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 Protected Health Information;

(h) The CONTRACTOR shall specify in its agreements with any agent or subcontractor of the CONTRACTOR that will have access to Protected Health Information 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;

(i) The CONTRACTOR shall make available to TENNCARE enrollees the right to amend their Protected Health Information 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;

(j) The CONTRACTOR shall make an enrollee's PHI data accessible to TENNCARE immediately upon request by TENNCARE;

(k) The CONTRACTOR shall make available to TENNCARE within ten (10) 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:

(1) the date of disclosure
(2) the name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person
(3) a brief description of the Protected Health Information disclosed, and
(4) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

In the event that the request for an accounting of disclosures is submitted directly to the CONTRACTOR, the CONTRACTOR shall within two (2) 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;

(l) The CONTRACTOR shall make its internal policies and procedures, records and other documentation related to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.

(m) The CONTRACTOR shall 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:

(1) Safeguards. CONTRACTOR agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI CONTRACTOR creates, receives, maintains, or transmits on behalf of TENNCARE.

(2) CONTRACTOR's Agents. CONTRACTOR agrees to ensure that any agent, including a subcontractor, to whom it provides EPHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the EPHI.

(3) Notification of Security Incident. CONTRACTOR agrees to report to TENNCARE any use or disclosure of TENNCARE enrollee PHI or of any security incident of which CONTRACTOR becomes aware.

(n) Upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with Sections 2-11 and 2-13 of this Agreement, the Contractor will, 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. The Contractor will complete such return or destruction as promptly as possible, but not later than 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 Section 2-11 and 2-13 of this Agreement . The Contractor will identify any PHI that cannot feasibly be returned to or destroyed. Within such 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 Section 2-11 and 2-13 of this Agreement the Contractor will: (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;

(o) The CONTRACTOR shall 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, including but not limited to, confidentiality requirements in 45 CFR parts 160 and 164;

(p) The CONTRACTOR shall set up appropriate mechanisms to ensure minimum necessary access of their staff to Protected Health Information;

(q) The CONTRACTOR shall 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;

(r) The CONTRACTOR shall 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;

(s) The CONTRACTOR shall 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;

(t) The CONTRACTOR shall be permitted to use and disclose PHI for the CONTRACTOR'S own legal responsibilities;

(u) The CONTRACTOR will adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for said CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization;

(v) The CONTRACTOR will continue to protect personally identifiable information relating to individuals who are deceased;

(w) The CONTRACTOR will be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;

(x) The CONTRACTOR must make available protected health information in accordance with 45 CFR § 164.524;

(y) The CONTRACTOR must make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526; and

(z) The CONTRACTOR shall obtain a third (3rd) party certification of their HIPAA transaction compliance before July 1, 2003.

2-3.w.2 In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:

(a) TENNCARE shall make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations.

(b) TENNCARE shall set up policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding plan administration and oversight.

(c) TENNCARE shall adopt a mechanism for resolving any issues of non-compliance as required by law.

(d) TENNCARE shall establish similar HIPAA data partner agreements with its subcontractors and other business associates.

2-4. Services Not Covered

The CONTRACTOR shall not pay for non-covered services as described in the TennCare Rules and Regulations at 1200-13-13-.10 and 1200-13-14.10. This includes, but is not limited to; medical services for individuals committed to penal institutions, whether local, state or federal; medical services performed outside the United States; any covered service that is not medically necessary. Further the CONTRACTOR is not obligated to pay for non-emergency services obtained out of plan.

2-5. Marketing and Enrollee Material

2-5.a. Marketing

The CONTRACTOR has the option to develop and implement a marketing plan and marketing materials. The CONTRACTOR's plan, materials and a description of all related activities must be submitted to TENNCARE for approval prior to implementation or use. All terms, conditions and policies stated herein apply to staff, agents, officers, subcontractors, providers, volunteers and anyone acting on behalf of the CONTRACTOR.

2-5.b. Enrollee Materials

The CONTRACTOR shall distribute various types of enrollee materials as required by this Agreement. These materials include, but may not be limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, or any other material necessary to provide information to enrollees as described herein and in Section 2-6.b, etc. The CONTRACTOR may distribute additional materials and information, other than those required by this Section, to enrollees in order to promote health and/or educate enrollees. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by TENNCARE prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this Agreement. Letters sent to enrollees in response to an individual query do not require prior approval. The required enrollee materials include the following:

2-5.b.1. Member Handbooks

The CONTRACTOR shall develop a member handbook and update it periodically based on a template provided by TENNCARE. Member handbooks must be distributed to enrollees within thirty (30) days of receipt of notice of enrollment in an MCO plan or prior to enrollee's beginning effective date as described in Section 2-6.b. and annually thereafter. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook 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 new or updated member handbooks are mailed to enrollees. 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 enrollees in the existing case. Upon notice by TENNCARE of material changes, the CONTRACTOR shall make the appropriate revisions to maintain and redistribute the member handbooks immediately. The CONTRACTOR shall, if determined by TENNCARE, maintain and provide two (2) separate versions of the CONTRACTOR's TennCare Member Handbook for the specific population being served for the purpose of describing Medicaid Benefits to the Medicaid population and Standard Benefits to the Standard population. A member handbook must also be distributed to all contracted providers

upon initial credentialing and annually thereafter and as handbooks are updated. 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. All revisions must be approved by TENNCARE prior to dissemination. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

2-5.b.1.(a) Must be in accordance with all applicable requirements as described in Section 2-5 of this Agreement;

2-5.b.1.(b) Shall include a table of contents;

2-5.b.1. (c) Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;

2-5.b.1. (d) Shall include a description of services provided including limitations, exclusions, and out-of-plan use;

2-5.b.1. (e) Shall include a description of TennCare cost share responsibilities for enrollees including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts. Further, the information shall indicate that the enrollee may not be billed for covered services except for the amounts of the specified TennCare cost share responsibilities and of their right to appeal in the event that they are billed;

2-5.b.1. (f) Shall include information about preventive services for adults and children, including EPSDT for Medicaid eligibles to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;

2-5.b.1. (g) Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;

2-5.b.1. (h) 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, the use of 911, locations of emergency settings and locations for post-stabilization services;

2-5.b.1. (i) Shall include information on how to access the primary care provider on a 24-hour basis. The handbook may encourage members to contact this 24-hour service when they have questions as to whether they should go to the emergency room;

2-5.b.1. (j) Shall include notice to the enrollee 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.E.. 97-35) and a complaint form on which to do so;

2-5.b.1. (k) Shall include appeal procedures as described in Section 2-8 of this Agreement;

2-5.b.1. (l) Shall include notice to the enrollee that in addition to the enrollee’s right to file an appeal for actions taken by the CONTRACTOR, the enrollee shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;

2-5.b.1. (m) Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100(a)(1) and NCQA's Standards and Guidelines for the Accreditation of MCOs;

2-5.b.1. (n) Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;

2-5.b.1. (o) Shall include notice to the enrollee that enrollment in the CONTRACTOR's plan invalidates any prior authorization for services granted by another plan but not utilized by the enrollee prior to the enrollee's enrollment into the CONTRACTOR's plan and notice of continuation of care when entering the CONTRACTOR's plan as described in Section 2-3.j.2.(i);

2-5.b.1. (p) Shall include notice to the enrollee 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;

2-5.b.1. (q) Shall include notice to the enrollee that a new enrollee may request to change MCO plans at anytime during the forty-five (45) day period immediately following their initial enrollment in a MCO plan, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This process will require the enrollee to notify the State in a form which will be prescribed by the State;

2-5.b.1. (r) Shall include notice to the enrollee that the enrollee may change plans during their annual recertification and at the next choice period as described in Section 2-6.a.11 of this Agreement and shall have a forty-five (45) day period immediately following the enrollment, as requested during said choice period, in a new plan to request to change plans, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE;

2-5.b.1. (s) Shall include notice to the enrollee of their right to disenroll from the TennCare program at any time with instructions to contact TENNCARE for disenrollment forms and additional information on disenrollment;

2-5.b.1. (t) Shall include member services toll free telephone numbers; including the TENNCARE Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare as well as the service/information that may be obtained from each line. The TennCare hotline number is 1-866-311-4287;

2-5.b.1 (u) 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;

2-5.b.1. (v) Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations;

2-5.b.1. (w) Shall include directions in order to obtain information that shall be made available upon request regarding the "structure and operation of the MCO" and "physician incentive plans";

2-5.b.1 (x) Shall include right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

2-5.b.1 (y) Shall be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and

2-5.b.1 (z) Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

Once templates are provided to the CONTRACTOR, the CONTRACTOR shall add MCO specific information as indicated in the template, prepare a mock copy and submit to TENNCARE for approval. If no changes are made to items 2-5.b.1(a) through (z), the CONTRACTOR shall be deemed TennCare compliant with the minimum requirements. At such time that TENNCARE provides the CONTRACTOR with edits or revisions to the member handbook, the CONTRACTOR shall agree to utilize the format and make appropriate additions and/or revisions as required by TENNCARE.

In addition to the prior approval requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE.

2-5.b.2. Quarterly Newsletter

(a) **General Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include the following information in each newsletter:

(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; and

(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;

(3) a notice to enrollees 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.E.. 97-35), and a Contractor phone number for doing so. The notice shall be in English and Spanish;

(4) for TennCare enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services;

(5) member services toll free telephone numbers; including the TennCare Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line as well as the service/information that may be obtained from each line; and

(6) the following information to report fraud: "To report fraud or abuse to OIG: You can call free 1-800-433-3982 OR Go online at www.state.tn.us/tenncare and click

on "Report Fraud." To report provider fraud or patient abuse to MFCU, call free 1-800-433-5454."

(b) **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.

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.

The CONTRACTOR shall include the following information in each newsletter:

(a) Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and

(b) 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

(c) TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

In order to satisfy the requirement to distribute the quarterly newsletters to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, 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 that the newsletters were mailed within the calendar quarter, the quantity, and the 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.

2-5.b.3. Identification Card

Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's plan or prior to enrollee's beginning effective date. The identification card must comply with all state and federal requirements. Once the identification card has been approved by TENNCARE the CONTRACTOR shall submit five (5) printed sample cards of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Prior to modifying an approved identification card the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE, or the identification card may be issued by TENNCARE in a format and content mutually agreed upon by the CONTRACTOR and TENNCARE. Regardless of whether the identification card is issued by the CONTRACTOR or TENNCARE, all expenses associated with production and mailing of the identification card shall be the responsibility of the CONTRACTOR.

2-5.b.4. Provider Directory

The CONTRACTOR shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan or prior to enrollee's beginning 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. 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 EPSDT screens. Enrollee provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee 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 enrollee provider directory. 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. These updates shall be maintained in accordance with Section 2-2.n of this Agreement.

2-5.c. Permissible Marketing and/or Communication Activities

The following marketing and/or enrollee communication activities shall be permitted under this contract pending approval of a marketing plan describing the time(s), place(s), intent, audience and other relevant information requested by TENNCARE.

2-5.c. 1. Distribution of general information through mass media;

2-5.c. 2. Telephone calls, mailings and home visits to current enrollees of the CONTRACTOR only for the sole purpose of educating current enrollees about services offered by or available through the contractor;

2-5.c. 3. General activities that benefit the entire community (e.g., health fairs, school activity sponsorships, and health education programs)

2-5.d. Prohibited Marketing and/or Communication Activities

The following information and activities are prohibited:

2-5.d. 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. Further the CONTRACTOR shall adhere to requirements for the written materials to assure that material is accurate and does not mislead, confuse or defraud the recipients or the state agency and materials shall be subject to review by the Medical Care Advisory Committee (MCAC);

2-5.d. 2. Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined by an enrollee, or similar techniques;

2-5.d. 3. Gifts and offers of material or financial gain as incentives to enroll;

2-5.d. 4. Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

2-5.d. 5. Direct solicitation of prospective enrollees;

2-5.d. 6. Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

2-5.d. 7. In accordance with federal requirements, independent marketing agents shall not be used 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;

2-5.d. 8. In accordance with federal requirements, the CONTRACTOR shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

2-5.e. Prior Approval Process for All Marketing Activities/Materials and Enrollee Materials

2-5.e. 1. If the CONTRACTOR chooses to prepare a marketing plan, the CONTRACTOR shall submit a detailed description of its marketing plan for approval. If the CONTRACTOR chooses to use marketing material previously approved for a prior event, the CONTRACTOR shall submit samples of these materials for review and approval with their submission. Further, The CONTRACTOR shall submit any materials it intends to use and a description of any marketing activities to be held prior to implementation or use. This includes but is not limited to all policies and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, newsletters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.

2-5.e. 2. All materials submitted by the CONTRACTOR shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. All written material submitted by the CONTRACTOR must be submitted on paper and electronic file media. 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, an electronic file for these materials may not be required. The electronic files, when required, must be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE cannot be processed.

2-5.e. 3. TENNCARE shall review the Contractor's marketing plan, marketing activity descriptions and materials and either approve, deny or return the plan and/or materials (with written comments) within fifteen (15) calendar days from the date of submission.

2-5.e. 4. Once materials have been approved by TENNCARE, the CONTRACTOR shall submit an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing

Coordinator within thirty (30) working 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.

2-5.e. 5. Marketing problems may not be evident from the materials submitted, but may become apparent upon use. TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify marketing plans, activities or materials after approval.

2-5.e. 6. Prior to modifying any approved marketing plan, marketing activity or material, the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification.

2-5.f. Written Material Guidelines

2-5.f. 1. All materials shall be worded at a 6th grade reading level, unless TENNCARE approves otherwise.

2-5.f. 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.

2-5.f. 3. All written materials shall be printed with an assurance of non-discrimination.

2-5.f. 4. The following shall not be used on marketing or communication material without the written approval of TENNCARE:

2-5.f .4.(a) The Seal of the State of Tennessee;

2-5.f .4.(b) The TennCare[sm] name unless the initials "SM" denoting a service mark, is superscripted to the right of the name;

2-5.f .4.(c) The word "free" can only be used if the service is no cost to all members. If members have cost share 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.

2-5.f .4.(d) The use of phrases to encourage enrollment such as "keep your doctor" implying that potential members can keep all of their physicians. Potential members in TennCare should not be led to think that they can continue to go to their current physician, unless that particular physician is part of that provider network. In order for the service to be paid for by TennCare, members may continue to see their physician only if the physician is participating in the same plan or if the plan approves care by the physician as an out-of-plan provider.

2-5.f. 5. All vital MCO documents and the member handbook must be translated and available in Spanish.

Within ninety (90) days of notification from TENNCARE, all vital MCO 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 1,000 enrollees, whichever is less.

2-5.f. 6. The CONTRACTOR shall develop a written procedure 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. The CONTRACTOR shall provide for these enrollees, language help-lines with specific numbers. The CONTRACTOR shall provide instruction for its staff and all direct service sub-contractors regarding the procedure.

2-5.f. 7. All written materials shall be made available in alternative formats for persons with special needs or appropriate interpretation services shall be provided by the CONTRACTOR.

2-5.f. 8. The CONTRACTOR shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2-5.g. Failure to Comply with Marketing and Enrollee Material Requirements

All services listed in marketing and enrollee materials must be provided as described and the materials must adhere to the requirements as described in this Agreement. Failure to comply with the marketing and communication limitations contained in this Agreement, including but not limited to the use of unapproved and/or disapproved marketing and communication material, may result in the imposition by TENNCARE of one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

2-5.g. 1. Revocation of previously authorized marketing methods;

2-5.g. 2. Refusal of TENNCARE to authorize new enrollments for a period specified by TENNCARE;

2-5.g. 3. Forfeiture by the CONTRACTOR of all or part of the fixed administrative fee payments for persons enrolled as a result of non-compliant marketing practices; and/or

2-5. g. 4. Application of sanctions and/or liquidated damages as provided in Section 4-8 of this Agreement.

2-6. Enrollment

2-6.a. Enrollment Guidelines

Eligibility determination and enrollment of TennCare eligible enrollees in the MCO's plan shall be the responsibility of TENNCARE. Persons who are eligible to enroll in TennCare pursuant to the provisions of the TennCare policies and/or TennCare Rules and Regulations as outlined in Section 1-6 of this Agreement, may do so according to the following guidelines:

2-6.a. 1. The TennCare Bureau has determined that there is an optimal size for a CONTRACTOR which allows the CONTRACTOR to be well capitalized, provide quality service, and take advantage of economies of scale. This optimal size is generally between 150,000 to 250,000 members with a maximum of approximately 300,000 members. If it is identified by TENNCARE that a CONTRACTOR has an excessive level of enrollment, TENNCARE will determine a CONTRACTOR ineligible to accept new enrollees, considering those circumstances described below, and will take all appropriate actions to maintain enrollment within these parameters. The CONTRACTOR’s total enrollment

should not exceed 300,000 members during the choice periods, enrollees will be enrolled in consideration of this maximum. Whenever the CONTRACTOR exceeds the maximum enrollment, at the TennCare Bureau's discretion, the CONTRACTOR will be directed to reduce its enrollment based on a plan established by the State which provides appropriate notice to the CONTRACTOR, allows appropriate choice of plan for the enrollee and meets the objectives of the TennCare program. During any choice period, CONTRACTOR shall not have enrollment at more than ninety percent (90%) of the maximum enrollment, to allow capacity for new enrollment between choice periods, unless the best interests of the TennCare program are otherwise served. If it is identified by TENNCARE that a CONTRACTOR has an excessive level of enrollment, TENNCARE may determine a CONTRACTOR ineligible to accept new enrollees. The State, in its absolute and sole discretion, reserves the right to allow for enrollment of enrollees in excess of the maximums established, when it determines that it is in the best interests of the TennCare program. However, the State shall transfer enrollees based on the demonstrated capacity of the CONTRACTOR. Examples of when the State may allow enrollment in the CONTRACTOR's plan when the plan has reached maximum enrollment include but are not limited to: 1) the enrollee is a member of the same household that is currently in the CONTRACTOR's plan, 2) it is determined necessary by TENNCARE due to an emergent or hardship case, 3) the enrollee had requested enrollment in the CONTRACTOR's plan prior to meeting the enrollment maximum or 4) enrollment in the plan is necessary to assure that appropriate enrollee choice options are available. Both TENNCARE and the CONTRACTOR recognize that TennCare's eligibility is dynamic and that management of a plan's maximum enrollment within exact limits may not be possible.

2-6.a. 2. The CONTRACTOR shall agree to accept a reasonable number of enrollees enrolled, or who have requested enrollment, whether the result of voluntary selection or non-discriminatory assignment, from any failed health plan in the CONTRACTOR's service area as well as any plan which is terminated in whole or in part, may become insolvent or discontinues service in the area for any reason. The transfer of membership may occur at any time during the calendar year. In either event, new risk adjustment values for the remaining plans shall be calculated for the purpose of determining Medical Fund Target as described in Section 3-10 of this Agreement except as specified in Section 2-6.a.12 of this Agreement. No enrollee from another health plan shall be transferred retroactively to the CONTRACTOR's plan except as specified in Section 2-6.a.12. For purposes of this requirement, the CONTRACTOR shall not be responsible for payment of any medical services incurred by such enrollees prior to the effective date of transfer to the CONTRACTOR's plan.

It is agreed by TENNCARE that to the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a community service area of the impending failure of one of the plans serving the area; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to accept enrollees from failed plans

2-6.a. 3. Except for any applicable TennCare policies and procedures requiring assignment in a health plan, all non-SSI applicants shall be required at the time of their application to select a plan from the plans available in the community service area where the applicant resides and the enrollee will be advised to seek medically necessary services during the period the application is pending only from providers in the network of the plan the applicant selected or was assigned. The parties to this Agreement recognize that in accordance with TennCare policies and procedures, if an enrollee requests enrollment in a specified MCO, the enrollee may be assigned 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 a community service area 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, the enrollee is a member of a vulnerable population that is to be enrolled in a specified MCO as defined by TENNCARE, etc. If an enrollee did not request enrollment in a specified MCO, the enrollee will be assigned to an MCO in accordance with TennCare policies and procedures. In either case, the effective date of enrollment may occur prior to the MCO being notified of the enrollee becoming a member of the plan. The CONTRACTOR shall not be liable for the cost of any medical care prior to the effective date of eligibility in the plan but shall be responsible for the costs of covered services obtained on or after 12:01 a.m. on the effective date of eligibility and shall receive fixed administrative fee payments for the enrollee from the effective date of eligibility.

2-6.a. 4. Enrollment shall be in the order in which applications are approved to the extent possible as provided by the enrollment procedures described herein.

2-6.a. 5. If an enrollee elects family coverage through TennCare, all enrollees in the household shall be enrolled in the same plan to the extent possible.

2-6.a. 6. The CONTRACTOR shall accept the enrollee in the health condition the enrollee is in at the time of enrollment.

2-6.a. 7. TENNCARE shall enroll only persons who reside within the community service area(s) within the Grand Regions in which the CONTRACTOR is authorized to serve.

2-6.a. 8. The CONTRACTOR shall continue to be responsible for the care of any enrollee moving outside the CONTRACTOR's authorized community service area(s) until such time as the enrollee selects or is assigned to a TennCare plan in the area where the enrollee has moved, or has been disenrolled from the MCO and enrolled in a new plan by TENNCARE. TENNCARE shall continue payment of fixed administrative fee payments to the CONTRACTOR on behalf of the enrollee until such time as the enrollee is enrolled in another MCO plan. The CONTRACTOR shall remain responsible for the provision and cost of medical care for the enrollee until such time as the enrollee is enrolled in another plan. TENNCARE shall notify the CONTRACTOR promptly upon enrollment of the enrollee in another plan.

2-6.a. 9. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in the TennCare policy and/or TennCare rules and regulations. Women who are determined presumptively eligible are given immediate TennCare eligibility and a temporary identification form to confirm eligibility pending the issuance of a regular identification card by their selected MCO. The purpose of this temporary identification/eligibility confirmation form is to enable the women to access prenatal care at the earliest possible time. In accordance with TennCare rules, policies and procedures, the effective date of enrollment may occur prior to the MCO being notified of the enrollee becoming a member of the plan. The CONTRACTOR shall be responsible for the provision and costs of all covered services during the period of enrollment.

2-6.a. 10. Enrollees in TennCare shall be enrolled in a health plan that is available in the community service area in which the enrollee resides. TENNCARE may assign enrollees to a health plan or enrollees may be given their choice of health plans available in the community service area, subject to the capacity of a given plan to accept additional enrollees and any

restrictions limiting enrollment levels established by TENNCARE. New enrollees becoming eligible for TennCare shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following enrollment in a MCO plan, to request to change MCO plans without regard to whether such enrollment is the result of selection or assignment. Once the initial forty-five (45) day period has expired, the individual shall remain a member of the designated plan until the following choice period, an appeal to change is decided in favor of the enrollee based on hardship criteria, until the enrollee moves outside the designated plan's service area or until they lose eligibility for TennCare.

2-6.a. 11. TENNCARE shall provide an opportunity for enrollees to change managed care health plans during an annual choice period that shall be determined by TENNCARE. The effective date of any changes resulting from said choice period shall be January 1 of the following year, unless otherwise specified by TENNCARE. TENNCARE shall notify the CONTRACTOR of timeframes for authorized choice periods. Enrollees who select a new managed care organization or who do not exercise their choice to select a new MCO and are assigned by TennCare during a choice period, shall have one (1) opportunity anytime during the forty-five (45) day period immediately following the specified enrollment effective date in an MCO plan, to request to change MCO plans without regard to whether such enrollment is the result of selection or enrollment in the CONTRACTOR's plan by TENNCARE. Once the initial forty-five (45) day period has expired, the individual shall remain a member of the designated plan until the following choice period, until the enrollee moves outside the designated plan's service area or until the enrollee loses eligibility for TennCare.

2-6.a. 12. It is the intent and policy of TENNCARE that TennCare-eligible newborn children and their Mothers, to the extent that the Mother is eligible for TennCare, be enrolled in the same CONTRACTOR health plan with the exception of children that are SSI eligible at birth. Children that are SSI eligible at birth shall be assigned to TennCare Select. Enrollment of the newborn child in the same plan as its Mother facilitates coverage and payment of the costs associated with delivery, facilitates coverage and payment of the newborn services provided after birth of the child but prior to establishment of individual TennCare eligibility for the child and provides a financial incentive to the CONTRACTOR to promote prenatal care as a means to reduce the risks of a complicated and more costly pregnancy and/or delivery.

It is recognized by TENNCARE and the CONTRACTOR that despite the best efforts of TENNCARE to assure enrollment of a newborn in the same plan as its Mother, due to the various means of enrollment in the TennCare Program, a newborn child may be inadvertently enrolled in a plan 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 child has been incorrectly enrolled in a plan different than its Mother. Upon receipt of such notice from a CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in a plan different than its Mother, TENNCARE shall immediately:

(a) Disenroll the newborn from the incorrect plan;
(b) Recoup any fixed administrative rate payments made to the CONTRACTOR for the newborn;
(c) Enroll the newborn in the same plan as its Mother with the same effective date as when the newborn child was enrolled in the incorrect plan; and
(d) Make fixed administrative rate payments to the correct plan for the period of coverage.

The plan in which the newborn child is correctly enrolled shall be responsible for the coverage and payment of TennCare-covered services provided to the newborn child for the full period of eligibility. The plan in which the newborn child was incorrectly enrolled shall have no liability for the coverage or payment of any TennCare-covered services provided, except as described below, during the period of incorrect plan assignment and TENNCARE shall have no liability for payment of the fixed administrative rate or payments for covered services to the CONTRACTOR in these cases.

There are circumstances in which a newborn child's Mother may not be eligible for participation in the TennCare program. Each CONTRACTOR shall be required to process claims received for services provided to newborn children within the time frames specified in Section 2-9.m 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 child, during any period of enrollment in the CONTRACTOR's plan, because the child's Mother is not a member of the CONTRACTOR's plan. However, it is recognized that in complying with the claims processing time frames specified in Section 2-9.m of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn child enrolled in the CONTRACTOR's plan at the time of payment but the child's eligibility may subsequently be moved to another contractor's plan. In such event, the CONTRACTOR in which the newborn child is first enrolled (first plan) may submit supporting documentation to the contractor's plan in which the newborn child is moved (second plan) and the second plan shall reimburse the first plan within thirty (30) days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the child prior to the child's eligibility having been moved to the second plan. Such reimbursement shall be the actual amount expended by the first plan. The second plan agrees that should the second plan fail to reimburse the first plan the actual amount expended on behalf of the newborn child within thirty (30) days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second plan and to reimburse the first plan. 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 4-8.b.2. Should it become necessary for TENNCARE to intervene in such cases, both the second plan and the first plan agree that TENNCARE shall be held harmless by both plans for actions taken to resolve the dispute.

2-6.a. 13. The CONTRACTOR or anyone acting on its behalf shall not submit enrollment applications or change requests.

Once enrolled, the individual's enrollment in the MCO's plan shall be maintained without a yearly re-enrollment in the MCO's plan unless this Agreement should expire or be terminated, the individual loses eligibility for TennCare, elects to change plans in accordance with the above provisions, moves outside of the service area or voluntarily withdraws from the TennCare program.

2-6.b. Enrollment Procedures

2-6.b. 1. The CONTRACTOR shall give a full written explanation of the MCO's plan to enrollees within thirty (30) calendar days after notification of their enrollment in the MCO or prior to the enrollee's beginning effective date, including but not limited to a member handbook and an identification card as described in Section 2-5 of this Agreement. In

addition to the information described above, this written explanation shall, at a minimum, also include:

2-6.b.1. (a) Effective date of enrollment;

2-6.b.1. (b) Names, locations, telephone numbers, office hours, non-English languages spoken by current network providers (including primary care providers, specialists and hospitals, including locations of emergency settings and post stabilization services), identification of providers accepting new patients and whether or not a provider performs EPSDT screens. 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 in the enrollee's TennCare case number when there is more than one (1) new enrollee in a case at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. These updates shall be maintained in accordance with Section 2-2.n of this Agreement;

2-6.b. 2. The CONTRACTOR shall provide all other information as required by CMS, including but not limited to the following:

The following information to any enrollee who requests it:

(a) information regarding the structure and operation of the CONTRACTOR's plan; and

(b) information regarding Physician Incentive Plans, including but not limited to:

(i) Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services.
(ii) The type of incentive arrangement.
(iii) Whether stop-loss protection is provided.
(iv) If the CONTRACTOR was required to conduct a survey, a summary of the survey results.

2-7. Disenrollment

In accordance with TennCare policy and/or TennCare rules and regulations, it shall be TENNCARE's responsibility to disenroll ineligible persons from the CONTRACTOR's plan.

2-7.a. Unacceptable Reasons for Disenrollment

The enrollment of an enrollee in the TennCare system may not be terminated from a designated health plan for any of the following reasons:

2-7.a. 1. Adverse changes in the enrollee's health;

2-7.a. 2. Pre-existing medical conditions;

2-7.a. 3. High cost medical bills;

2-7.a. 4. Failure or refusal to pay applicable cost sharing responsibilities except when TENNCARE has approved such disenrollment;

2-7.a. 5. Enrollee's utilization of medical services;

2-7.a. 6. Enrollee's diminished mental capacity; or

2-7.a. 7. Enrollee's uncooperative or disrupting 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).

2-7.b. CONTRACTOR's Responsibility for Disenrollments

The CONTRACTOR's responsibility for disenrollment shall be to:

2-7.b. 1. Inform each enrollee at the time of enrollment, of the criteria for disenrollment from the plan as permitted by TennCare policy and/or TennCare rules and regulations;

2-7.b. 2. Inform TENNCARE promptly, in the manner and media described in Section 2-10.b of this Agreement, when the CONTRACTOR knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations.

Actions taken by TENNCARE cannot be grieved to the CONTRACTOR.

2-8. Complaints and Appeals

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 2-5.b.1. 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.

The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2-9.j., to the review of member complaints and appeals that have been received.

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.

2-8.a. Appeals

The CONTRACTOR's appeal process shall include, at a minimum, the following:

2-8.a.1. The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should an enrollee choose to appeal in writing, the

enrollee will be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2-8.a.2. 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.

2-8.a.3. 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.

2-8.a.4. The CONTRACTOR shall identify the appropriate individual or body within the plan having decision-making authority as part of the appeal procedure.

2-8.a.5. 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.

2-8.a.6. Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2-8.a.7. The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2-8.a.8. 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.

2-8.a.9. The Contractor shall require providers to display notices of member's 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.

2-8.a.10 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.

2-8.a.11. 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.

2-8.a.12. 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.

2-8.a.13 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.

2-8.a.14. 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.

2-8.a.15. 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 2-3.d.5.

2-8.a.16. The CONTRACOR 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 (i.e., therapeutic duplication, etc.)

2-8.a.17. Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Department of Human Services.

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 4-8. of this Agreement.

2-9. Administration and Management

2-9.a. General Requirements

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the health plan covered there under. This includes all subcontracts, provider agreements, employees, agents, and anyone acting for or on behalf of the CONTRACTOR. All costs related to the administration of this Agreement that are non-medical in nature shall be the responsibility of the CONTRACTOR. Costs that are non-medical in nature shall include costs as defined in Section 1-3, as amended, as "Administrative Costs". Bonds shall be required for facility improvement or construction (over $100,000). However, MCOs under this contract are not bound by this requirement nor will the TennCare program reimburse for facility improvement or construction outside of the administrative fees paid by TENNCARE.

2-9.b. Performance Standards

The CONTRACTOR agrees TENNCARE may assess penalties for failure to meet the Performance Standards specified below during the Stabilization Period in addition to the intermediate sanctions and liquidated damages specified in Section 4-8. Penalties for failure to meet a performance standard shall not be passed on to a provider and/or subcontractor unless the penalty was caused due to an action or inaction of the provider and/or subcontractor.

TENNCARE shall not apply penalties for failure to meet Specialist Provider Network Standard C.1 and C.2 and Network Adequacy Standard D.1, specified in the table below, if the CONTRACTOR is able to demonstrate that the failure to satisfy the standard occurred after a change in provider agreement terms directed to be made by TENNCARE, and that the failure is related to the required change in provider agreement terms. All penalties shall be considered an administrative cost to the CONTRACTOR.

Performance Area	Data Sources	Definition	Standard	Penalty
A. Claims Payment Accuracy and Timeliness	Claims and Encounter Data Note: Self-reported based on internal audit conducted on statistically valid random sample on a quarterly basis. Audit procedures and sample methodology to be submitted to TDCI for review and approval with first quarter's report.	1. Accuracy: Number of claims processed for payment and paid accurately upon initial submission divided by the total number of claims. 2. Timeliness of Clean Claims Processing: Number of clean claims processed within 30 calendar days of receipt divided by the total number of clean claims received (for calculation date of receipt counts as day zero). Timeliness of Clean and Unclean Claims Processing: Number of claims processed and, if appropriate, paid within 60 days of receipt divided by the number of all claims processed (for calculation date of receipt counts as day zero) Processing To be measured and reported monthly	Accuracy: 97% of claims are processed or paid accurately upon initial submission Timeliness of Clean Claims Processing: ninety (90%) of clean claims are paid within 30 days of receipt of these claims. Timeliness of Clean and Unclean Claims Processing: 99.5% of all claims within sixty (60) days of receipt.	$5,000 for each full percentage point accuracy is below 97% for each quarter Development and implementation of a Corrective Action Plan pursuant to Section 2-16 for each month not in compliance and $10,000 for each quarter not in compliance Development and implementation of a Corrective Action Plan pursuant to Section 2-16 for each month not in compliance and $10,000 for each quarter not in compliance
B. Call Abandonment rate and call	ACD Line Productivity Reports for calls	**1.** Call Abandonment Rate: The number of calls abandoned by the	Call Abandonment rate: Less than 5% of calls abandoned	$25,000 for each full percentage point above 5%

Performance Area	Data Sources	Definition	Standard	Penalty
answer timeliness for Member Services line	where the member called directly into member services or selected a member services option and was put in the call queue. Refer to NCQA HEDIS Technical Specifications for further clarification and changes.	caller or the system before being answered by a live voice. Divided by the number of calls received by the MCO member services call center as (during member services open hours of operation) during the measurement period.		on a quarterly basis
		2. Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the measurement period.	85% of all Calls are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	$25,000 for each full percentage point below 85% on a quarterly basis
C. Call Abandonment rate and call answer timeliness for Utilization Management (review) line.	ACD Line Productivity Reports for calls where the provider/staff called directly into the UM call center or selected a UM call center option and was put in the call queue.	**1.** Call Abandonment Rate: 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 MCO UM call center (during UM open hours of operation) during the measurement period.	Call Abandonment rate: Less than five percent(5%) of calls abandoned	Development and implementation of a Corrective Action Plan pursuant to Section 2-16
		2. Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by	85% of all Calls answered by a live voice within thirty (30) seconds	Development and implementation of a Corrective Action Plan pursuant to Section 2-16

Performance Area	Data Sources	Definition	Standard	Penalty
		the number of calls received by the CONTRACTOR's UM call center(s) (during UM call center open hours of operation) during the measurement period.		
D. Specialist Provider Network	CONTRACTOR's credentialing reports	Executed contract is a signed agreement with a provider to participate in the Contractor's network	**1.** Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following nine specialists: cardiology; gastroenterology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; 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 one (1) Center of Excellence for AIDs	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The penalty may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physician supply in the area. The penalty may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE
E. Network Adequacy	**1.** Monthly Provider listings	**1.** Time and travel distance as measured by GeoAccess	**1.** Provider network includes sufficient numbers and geographical	**1.** $25,000 if ANY of the listed standards are not met, either

Performance Area	Data Sources	Definition	Standard	Penalty
			disbursement of providers in order to satisfy the Terms and Conditions for Access of the TennCare Waiver	individually or in combination on a monthly basis. The penalty may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE
	2. Most recent monthly provider listing and random phone surveys conducted by TENNCARE on a quarterly basis	**2.** Network validation	**2.** At least 90% of records for participating providers on the most recent monthly provider listing can be used to contact the provider and confirm the provider is participating in the MCO's network	**2.** $25,000 if less than 90% of records can be used to contact the provider and confirm participation on a quarterly basis. The penalty 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

Performance Area	Data Sources	Definition	Standard	Penalty
F. Encounter Data Submissions	TennCare Edit Reports	Error Threshold Exceeded	Less than 2% of file contains errors by submission due date	A maximum of $10,000 per month, or a per submission fine of $2500 for each failed submission. In the event TENNCARE provides less than ninety (90) calendar days advance notice prior to changing edits penalties shall not be applied.
G. EPSDT Screening	MCO Encounter Data	The EPSDT screening ratio, calculated in accordance with specifications for the CMS-416 report	Demonstrated active pursuit and completion of activities designed to increase the CONTRACTOR's EPSDT screening ratio	Development and implementation of a Corrective Action Plan pursuant to Section 2-16
H. CAHPS Survey Report	Annual Member Satisfaction Survey	A set of standardized surveys that measure patient satisfaction with experience of care	Report of annual CAHPS survey results due by June 15th. Rating of the Healthplan: CONTRACTOR must meet or exceed Medicaid National average as reported in Quality Compass. 2004 rating was 69.9%.	Development and implementation of a Corrective Action Plan pursuant to Section 2-16
I. HEDIS Report	Annual HEDIS measurement as required by NCQA	A set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans	Report of audited HEDIS data due by June 15th	Development and implementation of a Corrective Action Plan pursuant to Section 2-16

Performance Area	Data Sources	Definition	Standard	Penalty
J. Provider Satisfaction Survey Report	Annual Provider Satisfaction Survey	Survey of provider satisfaction with Prior Authorization process	Report due by June 15th	Development and implementation of a Corrective Action Plan pursuant to Section 2-16
K. NCQA Accreditation Report	NCQA	Final Accreditation Report in its entirety from NCQA's initial survey and annual revised accreditation status	Provisional Accreditation Denied Accreditation	Corrective Action Plan and possible Termination of Contract Termination of Contract

2-9.c. Staff Requirements

The staffing for the plan covered by this Agreement must be capable of fulfilling the requirements of this Agreement. The minimum staff requirements are as follows:

2-9.c. 1. A full-time administrator (project director) specifically identified to administer the day-to-day business activities of this Agreement;

2-9.c. 2. Sufficient full-time clinical and support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, complying with the requirements related to fraud as set forth in Section 1-5 of this Agreement, prior authorizations, medical and disease management, marketing, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;

2-9.c. 3. A physician who is licensed in the State of Tennessee to serve as medical director to oversee and be responsible for the proper provision of covered services to members;

2-9.c. 4. A person who is trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to TENNCARE;

2-9.c. 5. A specific Department of Children's Services (DCS) liaison person or persons shall be identified, in writing, to TENNCARE and the DCS within ten (10) calendar days of execution of this Amendment to be responsible for compliance with EPSDT requirements for children in custody and at risk and to coordinate care. This listing shall include, at a minimum, the names, titles, addresses and contact numbers (phone, fax, etc.) of each of the liaison persons. The liaison person(s) shall be available to TENNCARE and/or the Department of Children's Services (DCS) case managers and foster families for assistance. The number of specific liaison persons identified shall be adequate at all times to cover the number of children in State custody enrolled in TennCare. Any staff changes in the identified liaison person(s) shall be reported in writing to TENNCARE and DCS within ten (10) calendar days of the change. All changes in liaison persons shall include, at a minimum, the names, titles, addresses and contact numbers (phone, fax, etc.) of the new liaison person(s).

TENNCARE will coordinate the responsibility for training these liaisons on issues dealing with provision on EPSDT services to State custody children and those at risk. The liaisons will provide care coordination for these children within their respective MCOs and will have the responsibility of facilitating the timely delivery of EPSDT services covered by the MCO. "Care coordination" will include identifying providers, scheduling appointments, and coordinating transportation;

2-9.c. 6. The CONTRACTOR shall appoint a staff person as its Non-discrimination Compliance Coordinator to 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.E.. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR does not have to require that compliance with the aforementioned federal and state regulations be the sole function of the designated staff member. However, the CONTRACTOR shall identify the designated compliance staff member to TENNCARE by name. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to TENNCARE within ten (10) calendar days of the change;

2-9.c. 7. The CONTRACTOR shall appoint a staff person to be responsible for communicating with TENNCARE regarding member service issues. A member service line (member services hotline) staffed adequately to respond to enrollee's questions during normal business hours, five (5) days a week. The member service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to, EPSDT. Further, if the CONTRACTOR's service area is broad enough that any enrollee would have to call long distance, the CONTRACTOR shall make provisions for a toll free number or accept collect calls from enrollees and shall make such information available as to which of these options they have available. Said information may be made available pursuant to the CONTRACTOR's enrollee newsletter or materials distributed pursuant to Section 2-5 of this Agreement. The CONTRACTOR shall adequately staff the member service line to assure that the average wait time for assistance does not exceed ten (10) minutes. Failure to adequately staff and maintain average wait times of less than ten (10) minutes shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16 and may result in the CONTRACTOR being subject to liquidated damages and/or intermediate sanctions as described in Section 4-8 of this Agreement;

2-9.c. 8. The CONTRACTOR shall maintain a 1-800 Nurse Triage line that shall be available to members 24 hours a day, seven days a week. The 24/7 Nurse Triage line service shall provide health information/education to patients; healthcare counseling/telephone triage to assess health status in order to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings. The CONTRACTOR shall include information on the Nurse Triage line, including the telephone number and the services/information available by calling the line, in the member handbook and in quarterly member newsletters. The CONTRACTOR shall track and report on a quarterly basis 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 2-3.s.5 (h) of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-3.s.5 (j) of this Agreement.

2-9.c. 9. The CONTRACTOR shall appoint a staff person to be responsible for communicating with TENNCARE regarding provider service issues. Further, the CONTRACTOR shall have a provider service line staffed adequately to respond to providers questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in Section 2-3.d of this Agreement. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to, EPSDT. The CONTRACTOR shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed ten (10) minutes. Failure to adequately staff and maintain average wait times of less than ten (10) minutes shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16 and may result in the CONTRACTOR being subject to intermediate sanctions as described in Section 4-8 of this Agreement;

2-9.c. 10. The CONTRACTOR shall identify in writing key contact persons for Contract Administration, Accounting and Finance, Fraud Detection as set forth in Section 1-5 of this Agreement, Prior Authorizations, Marketing, Claims Processing, Information Systems, Non-discrimination Compliance, Member Services, Provider Services, Appeal System Resolution, Medical Management, Disease Management, HEDIS, CAHPS, NCQA Accreditation and EPSDT within thirty (30) days of Agreement execution. Any changes in staff persons during the term of this Agreement must be made in writing within ten (10) business days.

2-9.c. 11. The CONTRACTOR shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/BHO coordination issues as described in Section 2-3.c.2 of this Agreement. Further, the CONTRACTOR shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the MCO to the BHO, TENNCARE and TDMHDD.

2-9.c. 12. The CONTRACTOR shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Section 2-3.c.3 of this Agreement. Further, the CONTRACTOR shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the MCO to the DBM and TENNCARE.

2-9.c. 13. The CONTRACTOR shall appoint and identify in writing to TENNCARE a responsible contact available after hours for the “on-call” TennCare Solutions staff to contact with service issues, including but not limited to, pharmacy issues.

2-9.c. 14. The CONTRACTOR shall appoint specific staff to an internal audit department which shall report directly to the board of directors or other such appropriate level of management. The CONTRACTOR shall submit an annual Audit Plan to TENNCARE. The importance of an internal audit function is to provide an independent review and evaluation of the 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 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 internal audit department(s) shall be responsible for performance of the claims payment accuracy tests as described in Section 2-9 and 2-9.m.2 of this Agreement.

The CONTRACTOR's failure to comply with staffing requirements as described in this Agreement shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16 and may result in the application of liquidated damages and/or intermediate sanctions as described in Section 4-8.

2-9.d. Licensure of Staff

The CONTRACTOR is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision may result in one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

2-9.d. 1. TENNCARE may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;

2-9.d. 2. TENNCARE may refer the matter to the appropriate licensing authority for action;

2-9.d. 3. TENNCARE may assess liquidated damages as described in Section 4-8 of this Agreement; and

2-9.d. 4. TENNCARE may terminate this Agreement for cause as described in Section 4-2.b of this Agreement.

2-9.e. Employment of Personnel

A managed care organization may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity who has been debarred or suspended by any federal agency. A managed care organization 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:

2-9.e. 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;

2-9.e. 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 offence 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;

2-9.e. 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 b. of this certification; and

2-9.e. 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.

2-9.f. Subcontracts and Provider Agreements

All Subcontracts and revisions thereto, as defined in Section 1-3 of this Agreement shall be administered in accordance with Section 2-17 of this Agreement and shall be approved in advance by TENNCARE. Provider Agreements, as defined in Section 1-3 of this Agreement, shall be administered in accordance with and must contain all of the items listed in Section 2-18 of this Agreement. The CONTRACTOR shall freeze provider reimbursement rates, subject to updates per established reimbursement policies and procedures, as of April 16, 2002, unless otherwise approved or directed to modify reimbursement rates by TENNCARE. Only those provider agreements described in the following shall require prior approval by TENNCARE: any revision to reimbursement rate and/or methodology, all new or revised facility agreements, and all agreements with providers whose contract status changed from contracted to non-contracted then back to contracted with an increase in reimbursement from the prior agreement. All single case agreements shall be reported to TENNCARE; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears case agreements are being used to circumvent the "new contract review and approval process". . The CONTRACTOR agrees to revise Provider Agreements and Subcontracts as directed by TENNCARE. All template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMO's certificate of authority (COA) and any material modifications thereof.

No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to assure 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 and subcontractors to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement. The CONTRACTOR shall agree to not delegate responsibility for any activity being performed directly by the CONTRACTOR as of April 16, 2002 without the prior written approval of TENNCARE.

2-9.g. Data that must be Certified

When State payments to an MCO are based on data submitted by the MCO, the State must require certification of the data as provided in 42 CFR 438.606. 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. The data must be certified by one of the following: the MCO's Chief Executive Officer, The MCO's Chief Financial Officer, or An individual who has delegated authority to sign for, and who reports directly to the MCO's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:

2-9.g.1. To the accuracy, completeness and truthfulness of the data.
2-9.g.2. To the accuracy, completeness and truthfulness of the documents specified by the State.
2-9.g.3. The MCO must submit the certification concurrently with the certified data.

2-9.h. CONTRACTOR's Policies and Procedures

The CONTRACTOR shall administer this Agreement in accordance with the Policies and Procedures, including but not limited to, Medical Management Policies and Procedures, as defined in Section 1-3, as amended, in place as of April 16, 2002, unless otherwise directed or approved by TENNCARE. The State may review and approve all plan policies developed by the

CONTRACTOR related to administration and/or medical management of the TennCare Program. On an ongoing basis, should the CONTRACTOR have a question on policy determinations, including but not limited to, benefits or operating guidelines, the CONTRACTOR shall request a determination in writing. The State shall have thirty (30) calendar days to 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.

2-9.i. Medical Records Requirements

The CONTRACTOR shall maintain, and shall require contracted providers, 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. Medical records are to be maintained at the site where medical services are provided for each member enrolled under this Agreement. The CONTRACTOR shall have policies and distribute policies to practice sites that address:

2-9.i.1. Confidentiality of medical records;

2-9.i.2. Medical record documentation standards;

2-9.i.3. An organized medical record keeping system and standards for the availability of medical records, including but not limited to:

(a) Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request;

(b) When 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 case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

2-9.i.4. Performance goals to assess the quality of medical record keeping; and

2-9.i.5. CONTRACTOR medical record keeping policies and practices must be consistent with 42 CFR 456 and current NCQA Standards for medical record documentation.

2-9.j. Quality Monitoring/Quality Improvement (QM/QI) Program

The CONTRACTOR shall have a written Quality Improvement (QI) Program which clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This Program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the MCO's plan for improving patient safety. The CONTRACTOR shall agree to achieve and maintain NCQA Accreditation. NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. Additionally, for new MCOs contracting with TENNCARE, the Program shall be approved by TENNCARE prior to the enrollment of any TennCare enrollees. Any changes to the QI program structure shall require prior written approval from TENNCARE. The QI Program Description and associated work plan shall be submitted to TENNCARE annually for approval along with the Annual Evaluation of QI Program. The QI evaluation of the QI Program for the prior year, the revised QI Program Description and associated Work Plan shall be submitted to TENNCARE following approval by the CONTRACTOR's Quality Improvement Committee, no later than April 15th each year.

2-9.j.1. QM/QI Meeting Requirements

The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) days advance notice of all regularly scheduled meetings of the Quality Improvement Committee and Peer Review Committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the Quality Improvement Committee and/or Peer Review Committee meetings at his/her option. In addition, written minutes shall be kept of all meetings of the Quality Improvement Committee and Peer Review Committees. 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.

2-9.j.2. Clinical and Service Quality Improvement/Performance Improvement Activities

The CONTRACTOR shall perform three (3) clinical and two (2) service quality improvement activities relevant to the enrollee population. These Quality Improvement Activities may be used to meet NCQA requirements if applicable. Two of the three clinical activities shall be determined by TENNCARE. The TENNCARE selected clinical quality improvement activity topics are diabetes and maternity management. The following must be documented for each activity and CMS protocols for performance improvements projects (PIPs) must be met:

- Rationale for selection as a quality improvement activity
- Specific population targeted, include sampling methodology if relevant
- Metrics to determine meaningful improvement and baseline measurement
- Specific interventions (enrollee and provider)
- Relevant clinical practice guidelines
- Date of re-measurement

The CONTRACTOR shall electronically submit Quality Improvement Activity Forms as required by NCQA. These forms are available at www.NCQA.org.

2-9.j.3. Clinical Practice Guidelines

The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Guidelines must be distributed to all appropriate providers. The MCO 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 any revisions distributed to appropriate providers at least every two (2) years or whenever national guidelines change. The CONTRACTOR must submit the names of the clinical guidelines (ADA, AMA, etc.) along with a report on the results of performance measures utilized for each.

2-9.j.4. Performance Indicators

Performance indicator results shall be reported to TENNCARE within the Annual Evaluation of the Quality Improvement Program. Audited HEDIS and CAHPS results, including audit findings, shall be reported to TENNCARE by June 15th of each calendar year.

The CONTRACTOR's QI Work Plan shall identify benchmarks and set achievable performance goals for each selected quality measure. The source of the benchmark should be identified, i.e., Quality Compass. To be considered meaningful, 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
97-100	At least a 1 percentage point increase

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 2-16.

2-9.j.5. EPSDT (TENNderCare)

The CONTRACTOR agrees Section 2-9.j.5 shall be applicable for the period July 1, 2001 through June 30, 2002 only. To encourage significant improvement in EPSDT screening rates, a financial incentive equivalent to $0.32 per member per month (PMPM) shall be paid to an MCO that does not elect profit-sharing Option 2 for the achievement of four levels of performance.

Each MCO that improves its Adjusted Periodic Screening Percentage (APSP) by 10 percentage points will receive an incentive payment of $0.32 PMPM. In addition, each MCO that achieves an APSP of at least 60 percent will receive an incentive payment of $0.32 PMPM. A third and fourth payment can be earned for each additional ten (10) percentage point increase over 60 percent and up to 80 percent.

For the purpose of this section, the APSP shall be defined by multiplying the EPSDT screening ratio, calculated in accordance with specifications for the CMS-416 report, by the percentage of the required seven (7) components that are completed as determined through a statistically valid sample of medical records of the MCO's enrollees. The medical record review shall be conducted by TENNCARE.

To discourage decreases in EPSDT screening rates, each MCO that has not selected profit-loss sharing Option 2, with an APSP less than the minimum required rate shall be required to pay a penalty. The minimum required APSP for fiscal year 2002 shall be the average APSP for federal fiscal year 2000. The minimum required rate shall be revised annually by TENNCARE. The penalty amount shall be equivalent to 0.40% of the CONTRACTOR's fixed administrative fee payments for the applicable 12-month measurement period (July through June).

As specified at 2-3.n, any MCO including those participating in profit-loss sharing Option 2, that has an APSP of less than eighty (80) percent shall contract with each Local Health Department for the provision of EPSDT services in the community service area(s) in which it is authorized to serve.

2-9.j.6. Credentialing and Recredentialing

The CONTRACTOR utilizes current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentailing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. The CONTRACTOR shall further adhere to the credentialing requirements described in Section 2-3.k.6 of this Agreement regarding non-contract providers.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

2-9.j.7 NCQA Accreditation

NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. In order to assure that the CONTRACTOR is making forward progress, TENNCARE shall require the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2005	
Submit preliminary HEDIS data to EQRO as required by the CRA	July 1, 2005
Submit locked DST to NCQA	July 15, 2005
Purchase NCQA ISS Tool for 2006 MCO Accreditation Survey	August 1, 2005
Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO.	September 15, 2005
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 CAHPS Survey to TENNCARE	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 HEDIS Audit to TENNCARE	November 15, 2005
Submit copy of signed NCQA Survey Contract to TENNCARE	December 15, 2005
Notify TennCare of date for ISS Submission and NCQA Onsite review	December 31, 2005
CALENDAR YEAR 2006	
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor and TennCare	February 15, 2006

Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2006
Finalize preparations for NCQA Survey (final payment must be submitted to NCQA 60 days prior to submission of ISS.	July 1 – September 15, 2006
Submit ISS to NCQA	No later than September 18, 2006
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 12 months. Plan of Corrective Action addressing deficiencies noted by NCQA to TennCare within thirty (30) days of receipt of Final Report from NCQA. Provisional status may result in the assessment of liquidated damages or termination of this Agreement. • Accreditation Denied – Results in termination of this Agreement	December 31, 2006
CALENDAR YEAR 2007	
Complete NCQA Reconsideration Process (if necessary)	January 1, 2007-March 30, 2007
Complete Provisional NCQA Accreditation Resurvey NOTE: Provisional NCQA Accreditation may result in the assessment of liquidated damages or termination of this Agreement	December 31, 2007
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2007
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA
CALENDAR YEAR 2008	
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS* results submitted to NCQA and TennCare and the EQRO	June 15, 2008
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA

* Annually, 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

The CONTRACTOR may obtain additional payments for the successful achievement of NCQA Accreditation as described in Section 3-10.i.10 of this Agreement.

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 4-2.b of this Agreement. Further, failure to

achieve specified benchmarks or reporting requirements, as described in Section 4-8.b.2 shall result in damages as described therein.

Failure to obtain NCQA Accreditation by December 31, 2006 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 4-2.b of this Agreement. Achievement of Provisional accreditation status shall require a corrective action plan and may result in termination of this Agreement.

Following accreditation or re-accreditation, the CONTRACTOR must submit a copy of the bound report from NCQA" within 10 days of receipt of the report. The report from the accreditation process conducted in 2006 will be within 10 days of signature of this Agreement or within 10 days of receipt from NCQA which ever occurs later.

2-9.k. Financial Management

The CONTRACTOR shall be responsible for sound financial management of the plan. The CONTRACTOR must adhere to the minimum guidelines outlined below. In so doing, the CONTRACTOR shall at least:

2-9.k.1. Fixed Administrative Fee Payments

Agree to accept the fixed administrative fee payments that TENNCARE shall remit to the CONTRACTOR which are equal to the number of enrollees multiplied by the pro-rated fixed administrative rate established for each group, as described in Section 3-10. In addition, TENNCARE shall remit to the CONTRACTOR additional payments based on additions to the membership roster each month. Such additions shall be the result of additional enrollments and shall be limited to the period of eligibility as determined by TENNCARE as described in Section 2-6.a of this Agreement. These administrative fee payments are payment in full for all administrative costs incurred by the CONTRACTOR for providing or arranging for services in accordance with this Agreement.

When eligibility has been established by TENNCARE and the enrollee has incurred medical expenses that are covered benefits within the plan, the CONTRACTOR shall make reimbursement for the medical services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contract provider, the CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost share amounts. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost share amounts due from the enrollee as payment in full for the service.

2-9.k.2. Savings/Loss

The CONTRACTOR shall not be required to share with TENNCARE any portion of savings realized under this Agreement after the costs of all administrative expenses are paid. Should the actual amount for administrative costs exceed the fixed administrative rate, TENNCARE shall not be liable for any excess costs.

2-9.k.3. Return of Funds

The CONTRACTOR shall return to TENNCARE any overpayments due or funds disallowed pursuant to the terms of this Agreement. Such funds shall be considered TENNCARE funds and shall be refunded to TENNCARE. The refund shall be due within thirty (30) calendar days after notification to the CONTRACTOR by TENNCARE unless otherwise authorized by TENNCARE in writing. Upon failure to return funds due TENNCARE within thirty (30) calendar days, the Bureau of TENNCARE shall recover these funds from any current or future funds that may be owed the CONTRACTOR.

2-9.k.4. Financial Reserves

At a minimum, the CONTRACTOR shall establish and maintain the minimum net worth requirements and financial reserves required by the Tennessee Department of Commerce and Insurance of health maintenance organizations licensed by the State of Tennessee, including but not limited to the reserves required by Tennessee Code Annotated, Section 56-32-212 as amended. The CONTRACTOR acknowledges that any and all payments made by TENNCARE to the CONTRACTOR, including payments made during any period in which the CONTRACTOR is not at risk for the cost of Covered Services, are considered "Premium revenue" for the purpose of calculating the financial reserves required by Tennessee Code Annotated, Section 56-32-212 as amended. The CONTRACTOR shall demonstrate evidence of its compliance with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, (TDCI) in the financial reports filed with that Department by the CONTRACTOR. The CONTRACTOR agrees that failure to maintain any of the financial requirements in accordance with this Section 2-9.k.4 through 2-9.k.4(c), as determined by TDCI, shall constitute hazardous financial conditions as defined by Tennessee Code Annotated, Section 56-32-212 as amended.

At such time that the CONTRACTOR assumes full or partial risk for costs in accordance with the terms of this Agreement, requirements described in Sections 2-9.k.4(a), (b), and (c) below shall apply:

2-9.k.4(a) Statutory Net Worth for Enhanced Enrollment

The CONTRACTOR agrees that in order to maintain the minimum net worth requirements described in Tennessee Code Annotated, Section 56-32-212, the minimum net worth requirements are to be recalculated if a significant enrollment expansion as defined in Tennessee Code Annotated, Section 56-32-203(c)(2) is to occur. This calculation would 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 historical eligibility rate categories and projected future enrollment. The formula set forth in Tennessee Code Annotated, Section 56-32-212(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement. Before the CONTRACTOR is assigned the additional enrollees by TennCare, the CONTRACTOR must demonstrate to the satisfaction of TDCI that this enhanced minimum net worth balance has been established. The CONTRACTOR shall maintain the greater of the enhanced minimum net worth balance or the minimum net worth balance calculated pursuant to Tennessee Code Annotated, Section 56-32-212, until the CONTRACTOR has completed a full calendar year with the significantly expanded enrollment.

2-9.k.4(b) Restricted Deposits

The CONTRACTOR agrees to achieve and maintain restricted deposits in an amount equal to the statutory net worth requirement described in Tennessee Code Annotated, Section 56-32-212. For purposes of calculating the increased restricted deposits amount, TDCI shall calculate the amount based on the CONTRACTOR's TennCare revenue only unless the increased calculated amount is below the statutory requirements set forth in Tennessee Code Annotated, Section 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.

2-9.k.4(c) Liquidity Ratio Requirement

In addition to the positive working capital requirement described in Tennessee Code Annotated, Section 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.

2-9.k.5. Interest

Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

2-9.k.6. Third Party Resources (TPL)

The CONTRACTOR shall be the payer of last resort for all medical services in accordance with federal regulations. The CONTRACTOR shall exercise, full assigned benefit rights and/or subrogation 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 recover any such liability from the third party. The CONTRACTOR shall post all third party payments to claim level detail by enrollee. Unless otherwise indicated below, claims for which the CONTRACTOR's files indicate TPL exists, but does not reflect third party payment shall be denied. Further, in accordance with Section 2-10.b, the CONTRACTOR shall report to TENNCARE any information regarding an enrollee's third party resources in a format and media as described by TENNCARE.

2-9.k.6.(a) If the CONTRACTOR has determined that TPL exists for part or all of the services administered directly by the CONTRACTOR the CONTRACTOR shall make reasonable efforts to recover from third party liable sources the value of services rendered.

2-9.k.6.(b) If the CONTRACTOR has determined that TPL exists for part or all of the services provided to an enrollee by a provider, the CONTRACTOR shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of TPL. The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE.

2-9.k.6.(c) The CONTRACTOR may not withhold payment for services provided to a member if TPL or the amount of liability cannot be determined, or payment will not be available within a reasonable time. Except for the claims described below, if the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR must

reject the claim and return it to the provider for a determination of the amount of any third party payment. The claims exceptions are EPSDT, prenatal or preventive pediatric care, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act. These claims will be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party. When the amount of payment is determined, the CONTRACTOR shall pay the claim at the rate allowed under the CONTRACTOR's payment schedule. In no instance shall the amount of the third party payment and the CONTRACTOR's payment exceed the provider's contracted TennCare rate.

2-9.k.6.(d) All funds recovered from third parties will be treated 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 2-10. of this Agreement.

2-9.kl.6.(e) TennCare Cost sharing responsibilities permitted pursuant to Section 2-3.i of this Agreement shall not be considered third party resources for purposes of this requirement.

2-9.k.6.(f) The CONTRACTOR shall provide third party resource (TPR) data to any provider having a claim denied by the CONTRACTOR based upon a TPR.

2-9.k.6.(g) The CONTRACTOR shall provide any 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.

2-9.k.6.(h) 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 the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

2-9.k.6.(i) The CONTRACTOR shall not make payment on a claim that has been denied by a third party payor 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., unless otherwise directed by TENNCARE to do so.

2-9.k.6.(j) TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 4-8 of this Agreement. It shall be the CONTRACTOR's responsibility to 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.

2-9.k.7. Subrogation (Casualty) Recovery

The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation related claims. This editing should, at a minimum, identify claims with a diagnosis of 800.00 thru 999.99 (excluding 994.6) or a claim submitted with an accident trauma indicator of 'Y'. TENNCARE approved questionnaires or other type TENNCARE approved forms shall be used to gather data and information pertinent to potential subrogation cases. TENNCARE shall determine a threshold amount for which a subrogation case should be pursued. The CONTRACTOR shall develop and utilize guidelines which have been approved by TENNCARE to settle subrogation cases. The CONTRACTOR shall submit subrogation recovery guidelines to TENNCARE for review and approval by January 15th each year and prior to subsequent changes thereafter. TENNCARE shall respond to the CONTRACTOR's request within fifteen (15) calendar days of the CONTRACTOR's submission of the subrogation recovery guidelines.

2-9.l. Responding to Enrollee Complaints or Appeals

All enrollees shall be afforded the right to file a complaint and/or appeal. The CONTRACTOR shall refer all enrollees who are dissatisfied with the managed care organization's initial response to the complaint/appeal coordinator for the appropriate action in accordance with Section 2-8 of this Agreement. The CONTRACTOR's failure to comply with this Section shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16 and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 4-8.

2-9.m. Claims Processing Requirements

2-9.m.1. Timeliness of Payments

The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing 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.). To the extent that the CONTRACTOR compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement. The CONTRACTOR shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The CONTRACTOR shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare Program. The terms "processed and paid" are synonymous with terms 'process and pay' of Tennessee Code Annotated § 56-32-226(b)(1)(A) and (B). 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 notice must 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.

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 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 fixed administrative fee payment and supporting Remittance Advice information from TENNCARE.

The CONTRACTOR shall contract with independent reviewers for the purposes to review disputed claims as provided by T.C.A., Section 56-32-226.

2-9.m.2. Claims Payment Accuracy – Minimum Audit Procedures

The quarterly claims payment accuracy percentage is self-reported and is based on an audit conducted by the internal audit staff. The audit will 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 Tennessee Code Annotated § 56-32-226(b)(1)(A) and (B)).

A minimum sample of size of 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. Combining the results of minimum sub-samples of 100 randomly selected from the entire population of claim processed and paid upon initial submission for each month in the quarter is acceptable. The minimum attributes to be tested for each claim selected must include:

- Claim data correctly entered into the claims processing system
- Claim is associated to the correct provider
- Service obtained the proper authorization
- Member eligibility at processing date correctly applied
- Allowed payment amount agrees with contracted rate
- Duplicate payment of the same claim has not occurred
- Denial reason applied appropriate
- Copayment application considered and applied
- Effect of modifier codes correctly applied
- Processing considered if service subject to benefit limits considered and applied
- Other insurance properly considered and applied

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:

- Results for each attribute tested for each claim selected
- Amount of overpayment or underpayment for claims processed or paid in error
- Explanation of the erroneous processing for each claim processed or paid in error
- 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
- Claims processed or paid in error have been corrected

2-9.m.3. Electronic Billing

The CONTRACTOR shall provide the capability of electronic billing. The CONTRACTOR or any entities acting on behalf of the CONTRACTOR, shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The CONTRACTOR shall comply at all times with standardized paper billing forms/format as follows:

Claim Type	Claim Form

Professional	CMS 1500
Institutional	UB-92
Pharmacy	NCPDP (Edit Format)
Dental	ADA

2-9.m.4. Standard Forms and Billing Instructions

The CONTRACTOR shall not revise or modify the standardized forms or format itself specified in item 2 above. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups. This shall include, but not be limited to, 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 which requires a statement that the provider certifies that s/he is aware that payment is from Federal and State funds and anyone who misrepresents or falsifies essential Medicaid claims information may be prosecuted under Federal and State laws.

2-9.m.5. Edits

The CONTRACTOR shall perform front end system edits, including but not limited to, TPL, medical necessity (e.g., appropriate age/sex for procedure) and post-payment review on a sample of claims to ensure services provided were medically necessary. The CONTRACTOR must have a staff qualified, medically trained and appropriately licensed personnel, consistent with accreditation standards of NCQA, JCAHO or URAC whose primary duties are to assist in evaluating claims for medical necessity.

2-9.m.6. Timely Filing

Consistent with the requirements outlined in Section 2-18.v of this Agreement, the CONTRACTOR shall not deny provider claims on the basis of timely 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 plan with a retroactive eligibility date. In situations of third party benefits, the minimum and 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 plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility.

2-9.m.7. HIPAA Compliance

The CONTRACTOR agrees to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA). Further, the CONTRACTOR agrees that at such time that the Steering Committee presents TENNCARE with recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within one hundred and eighty (180) days from notice by TENNCARE to do so.

2-9.m.8. Eligibility for Services

The CONTRACTOR shall confirm 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. The CONTRACTOR shall process said claims, in an accurate manner in accordance with this Agreement.

2-9.m.9. EPSDT (TENNderCare) Reimbursement

For all provider agreements executed after July 1, 2002, the CONTRACTOR shall reimburse EPSDT (TENNderCare) screening services provided by a Primary Care Provider on a fee-for-service basis.

2-9.m.10 Explanation of Benefits (EOBs)

The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE. The MCO will omit any claims in the EOB file that are associated with sensitive services. Each MCO, with guidance from TennCare, will develop "sensitive services" logic to be used in eliminating these claims from generating an EOB. At a minimum, EOBs shall be designed to address CMS requirements found in 42 CFR Sections 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).

Regarding the paid claims, the CONTRACTOR shall stratify the sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the MCO considers a particular specialty (or provider) to warrant closer scrutiny, the MCO may over sample the group. The paid claims sample should be a minimum of 25 claims per check run (or 100 claims a month).

Based on the EOBs sent to the TennCare enrollees, the MCO will track any complaints received from enrollees and resolve the complaints according to MCO established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The MCO will use the feedback received to modify or enhance the EOB sampling methodology. Reporting of this process shall be described in Section 2-10 of this Agreement.

2-9.m.11. Remittance Advice to Providers

The CONTRACTOR shall provide a HIPAA compliant electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as fixed administrative fee payments generated and paid by the MCO. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data. 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.

In accordance with 42 CFR 455.18 and 455.19, the following statement must be including 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.''

2-9.m.12. Encounter Data

The CONTRACTOR shall submit encounter data to TENNCARE in accordance with Section 2-10. Encounter data shall include detailed information, including but not limited to applicable cost share responsibilities, TPL collections and shall contain all data elements required by TENNCARE and described in Attachment XI, Exhibit G.

2-9.m.13. Overpayment due to CONTRACTOR Error

The CONTRACTOR shall use its best efforts to recover overpayment of benefits that result from errors of the CONTRACTOR. Should the CONTRACTOR inadvertently make payment, arising from errors in overpayment, the amount of overpayment actually recovered should be credited to the State within forty-five (45) calendar days after recovery of the overpaid funds by the CONTRACTOR. In the event any overpayment is not recovered within 90 calendar days of discovery of the overpayment – and if the State has already made payment of the claims that included the overpayment – the CONTRACTOR will credit the State for the amount of the overpayment by the ninetieth (90) day.

2-9.m.14. Overpayment due to Provider Error

Overpayments due to provider billing errors and provider fraud or fraud of any other type, other than fraud by employees or contractors of the CONTRACTOR, will not be considered overpayments due to errors of the CONTRACTOR. In addition, the State will not hold the CONTRACTOR responsible for overpayment caused by the State's omission or errors in certifying eligibility; however, the CONTRACTOR is required to assist in recovery of overpayments due to provider billing errors or due to State errors or omissions.

2-9.m.15. Liquidated Damages/Sanctions

Failure to meet claims processing requirements shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 4-8, or if the deficiencies are severe, may result in the termination of this Agreement for cause as described in Section 4-2 of this Agreement.

2-9.n. Network Management

The CONTRACTOR shall provide or assure the provision of all covered services specified in Section 2-3.a of this Agreement. The CONTRACTOR may provide these services directly or may enter into written agreements with providers and provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment by the CONTRACTOR for services rendered.

2-9.n.1. Should the CONTRACTOR elect to contract with providers for the provision of covered services, the CONTRACTOR shall adhere to the following:

(a) The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program.

(b) The CONTRACTOR shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.

(c) The CONTRACTOR shall 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.

(d) If the CONTRACTOR declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(e) The CONTRACTOR shall maintain all provider agreements in accordance with the provisions specified in Title 42, CFR §438.12, 438.214 and Section 2-18 of this Agreement.

(f) The CONTRACTOR shall freeze provider reimbursement rates at the rate being paid as of April 16, 2002, subject to updates per established reimbursement policies and procedures in place, and negotiate changes in reimbursement rates as required by TENNCARE. Any change in rate payment methodology must be approved by TENNCARE.

2-9.n.2. Section 2-9.n.1 shall not be construed to:

(a) Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its enrollees;

(b) Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(c) Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees.

2-9.n.3. 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 an enrollee who is his or her patient for the following:

(a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self administered;

(b) Any information the enrollee needs in order to decide among all relevant treatment options;

(c) The risks , benefits, and consequences of treatment or non-treatment; or

(d) The enrollee'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.

2-9.n.4. The CONTRACTOR shall ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

2-9.n.5. The CONTRACTOR shall notify and make TENNCARE and TDCI TennCare Division aware of any operations or plans to operate a Physician Incentive Plan (PIP). Prior to implementation of any such plans, CONTRACTOR shall submit to TDCI TennCare Division any provider agreement templates or subcontracts that involve a PIP for review as a material modification. CONTRACTOR shall not implement a PIP in the absence of TDCI TennCare Division review and approval, which review will include review for compliance with applicable state and federal law. If the CONTRACTOR operates a PIP, the CONTRACTOR shall assure 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. 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:

(a) Whether services not furnished by the physician or physician group are covered by the incentive plan.

(b) The type or types of incentive arrangements, such as, withholds, bonus, capitation.

(c) The percent of any withhold or bonus the plan uses.

(d) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.

(e) The patient panel size and, if the plan uses pooling, the pooling method.

(f) If the CONTRACTOR is required to conduct enrollee surveys, a summary of the survey results.

2-9.n.6. For purposes of network management, the CONTRACTOR shall, at a minimum, adhere to and/or provide for the following:

(a) The CONTRACTOR shall notify all network providers to file claims associated with their services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

(b) The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to utilization management procedures.

(c) PCP Profiling. The CONTRACTOR shall profile TennCare PCP's. A summary of PCP profiling activities will be provided to the TennCare Chief Medical Officer quarterly. The summary will include a listing of PCPs whose profiling revealed practice patterns greater than or equal to two standard deviations from the norm within the CONTRACTOR's network. The summary should include specific actions taken for identified outliers. PCP profiling will include, but not be limited to the following:

(1) Out-of-Network Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee out-of-network utilization by PCP panel.

(2) Specialist Referrals. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee Specialty provider utilization by PCP panel

(3) Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee emergency room utilization by PCP panel and provide a report to TENNCARE as described in Section 2-10.p.2 of this Agreement. Individual enrollees who establish a pattern of accessing emergency room services should be referred to case management for follow-up.

(4) Inpatient Admissions. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee utilization of inpatient services by PCP panel.

(5) Pharmacy Utilization. At a minimum, the CONTRACTOR shall comply with the following:

(a) Generic versus Brand Name. The CONTACTOR shall maintain a procedure to incorporate pharmacy utilization (generics versus brand names) into the PCP profile.

(b) Outlier Reports for Narcotic Prescriptions. TENNCARE shall provide the CONTRACTOR a semiannual report listing TennCare providers who appear to be outliers with regard to the numbers and percentages of narcotic prescriptions they write. The CONTRACTOR shall assess the prescribing practices of all contracted providers and report back to the Bureau regarding their findings. The report will either provide assurance that the prescriber appears to be practicing their specialty in accordance with acceptable standards of care or will provide a plan to address any identified concern.

(6) Advanced Imaging Procedures. The CONTRACTOR shall maintain a procedure to identify and evaluate utilization of advanced imaging procedures by PCP panel. Advanced Imaging Procedures include: PET Scans; CAT Scans and MRIs.

(d) Practice Pattern Analysis. The CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back outlier information as requested by TENNCARE.

2-9.o Business Continuity and Disaster Recovery (BC-DR) Plan

(a) 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. TENNCARE shall provide guidance to the CONTRACTOR regarding its BC-DR plan in a Standard Operating Procedure.

(b) 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.

(c) 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.

(d) 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.

(e) The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 2.10.l.

2-10. Reporting Requirements

2-10.a. General Requirements

The CONTRACTOR is responsible for complying with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. TENNCARE may, at its discretion, require the CONTRACTOR to submit new reports, to recreate, reconstruct or re-sort reports using the same or different reporting formats, instructions and submission timetables as specified by TENNCARE. Requests to submit new reports, recreate, reconstruct or re-sort said reports may be considered Ad Hoc reports or continuous reports and shall be due in accordance with the provisions in Section 4-8 of this Agreement. The minimum data elements required for reporting are outlined in Attachment XII of this Agreement.

TENNCARE may require the CONTRACTOR to submit reports via e-mail in place of hard copy reports or a mutually agreed upon electronic process. The CONTRACTOR shall transmit/receive from/to 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.

Failure to report information, as specified by TENNCARE, shall result in the assessment of liquidated damages as described in Section 4-8 of this Agreement.

2-10.b. Reporting Enrollee Information

The CONTRACTOR shall comply with reporting requirements that are developed by TENNCARE in order to reconcile TENNCARE/MCO enrollment files and verify that both TENNCARE and the CONTRACTOR maintains accurate enrollee information.

2-10.b.1. Enrollee Information, Weekly Reporting

The CONTRACTOR shall submit weekly reports in an electronic format, unless otherwise specified or approved by TENNCARE in writing, which shall serve as the source of information for a change in the enrollee's TennCare information. Such information shall serve as the source of information for a change in the enrollee’s address and/or selection of MCO plan. This report shall include enrollees who move outside the CONTRACTOR’s service area as well as enrollees who move to a new address within the CONTRACTOR’s service area. The CONTRACTOR agrees to work with the State to devise a methodology to use returned mail to identify enrollees who have moved and whose whereabouts is unknown.

Within ninety (90) days of the time that TENNCARE develops and describes to the CONTRACTOR the new reporting procedures, the CONTRACTOR shall also be required to include in the report, described above, any information which is known by the CONTRACTOR that may affect an enrollee’s TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the enrollee is incarcerated, or resides outside the State of Tennessee. The minimum data elements that will be required for this report can be found in Attachment XII, Exhibit A of this Agreement.

The CONTRACTOR shall gather, store and update a minimum of the following health insurance information:

- Recipient SSN
- Type of Coverage (Inpatient, outpatient, pharmacy, dental, vision, etc.)
- Policyholder name
- Policyholder SSN, if available
- Policyholder's relationship to the recipient
- TennCare Carrier Number, Carrier name and address, if available
- Policy number
- Begin and end dates of policy.

Health insurance data provided by the CONTRACTOR that does not include the above required fields will be returned to the CONTRACTOR.

2-10.b.2. Enrollee Verification Information, On Request

TENNCARE may provide the CONTRACTOR with a report in electronic format containing enrollees for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this report, the CONTRACTOR shall immediately, or within time frames, if any, specified by TENNCARE, provide TENNCARE with any information that is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability, including limited coverage and exclusionary riders to policies, information regarding an enrollee which has been incarcerated, change of residence or residence outside the State of Tennessee. TENNCARE shall not specify timeframes less than thirty (30) calendar days from the CONTRACTOR's receipt of such report. The minimum data elements required for this report can be found in Attachment XII, Exhibit B of this Agreement

2-10.b.3. Eligibility and Premium Reconciliation

On a monthly basis, the CONTRACTOR shall reconcile enrollee eligibility data and the fixed administrative fee payments and submit written verification that the CONTRACTOR has an enrollment record for all enrollees for whom the CONTRACTOR has received a fixed administrative fee payment. The CONTRACTOR shall also notify TENNCARE in the event it has enrollees for whom an administrative payment has not been made or an incorrect payment has been made. This report shall be submitted as follows:

1. On a quarterly basis or as approved by TENNCARE, with a one-month lag time. The report is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30th, the report is due by the end of November and should include all data received through the end of October.

2. Reports shall include un-reconciled items on all reports until such time that TENNCARE notifies the CONTRACTOR otherwise.

3. The CONTRACTOR shall report this information in the formats described in Attachment XII, Exhibit M.

2-10.b.4. Enrollee Cost Sharing

In accordance with Section 2-3.i, the CONTRACTOR shall report enrollee cost-sharing liabilities on a quarterly basis in the manner and form described by TENNCARE.

2-10.b.5. Enrollee EOB Reporting

In accordance with Section 2-9.m.10 of this Agreement, a quarterly report will be sent to the Office of Contract Compliance and Performance delineating the number of EOBs sent by category, enrollee complaints, and complaint resolution (including referral to TBI/OIG). The quarterly report is due thirty (30) days after the end of the quarter.

2-10.c. Provider Enrollment Reporting

2-10.c.1. Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

Thereafter, a complete electronic provider replacement file (full file refresh) shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number) as well as the National Provider Identifier (NPI) Number, effective May 23, 2007. These unique identifiers shall appear on all encounter data transmittals.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracting providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 4-8 of this Agreement.

2-10.c.2. Essential Hospital Services Chart

In accordance with Section 2-3.b.2(1) the CONTRACTOR shall submit a hard copy report listing of essential hospital providers that are included in the CONTRACTOR's

provider network on the Essential Hospital Services Chart in Attachment XII, Exhibit D by September 1 of each year for each of the Grand Regions in which it operates.

2-10.c.3. Specialty Physician Services Chart

In accordance with Section 2-3.b.2(3) the CONTRACTOR may submit a hard copy report listing of specialty physician arrangements that the CONTRACTOR has in place on the Specialty Physician Services Chart in Attachment XII, Exhibit E by September 1 of each year, for each of the community service areas in which it serves.

2-10.d. Reporting of Other Insurance

If the CONTRACTOR operates or administers any non-Medicaid HMOs, health plan(s) or other lines of business, the CONTRACTOR agrees to assist TENNCARE with the identification of enrollees with access to other insurance. The method and procedure for identifying enrollees shall be mutually agreed upon by the CONTRACTOR and the State. The proposed minimum data elements that may be requested to assist with the identification of enrollees with access to other insurance can be found in Attachment XII, Exhibit F of this Agreement.

2-10.e. Medical Services Payment Reporting

2-10.e.1 Individual Encounter Reporting

Individual encounter/claim data shall be reported in a standardized format as specified by TENNCARE and transmitted electronically to TENNCARE on a weekly basis. In the event a national standardized encounter reporting format is developed, the CONTRACTOR agrees to implement this format if directed to do so by TENNCARE. The minimum data elements required to be provided are identified in Attachment XII, Exhibit G of this Agreement.

2-10.e.2. TPL Reporting

(a) Cost Avoidance Value Reporting. The CONTRACTOR shall report all claim adjustment amounts due to TPL coverage or Medicare coverage on a frequency and in a format and media described by TENNCARE. The CONTRACTOR shall calculate cost savings in categories described by TENNCARE.

(b) Subrogation Recoveries. On a monthly basis, the CONTRACTOR shall report to TENNCARE the amount of any subrogation recoveries collected outside the claims processing system received during the previous month.

2-10.e.3. Reporting Provider Payment Issues

(a) If the CONTRACTOR does not automatically credit TENNCARE for receivables within ninety (90) calendar days, the CONTRACTOR shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts 45 Day	90 Day	Forwarded to Collections
< $10	None Required		
$10 - $49.99	✓		
$50 - $99.99	✓	✓	

$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.

Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

Failure to send the notices as scheduled may result in liquidated damages as described in Section 4-8 of this Agreement.

(b) If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Aged Accounts Receivable report". The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.

(c) If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Uncollectible Accounts Report", in a format described by TENNCARE, for accounts meeting the following criteria:
(1) the account proves to be uncollectible after 120 calendar days, or
(2) the provider account owner has gone out-of-business, or
(3) the provider account owner has declared bankruptcy.

In addition to the "Uncollectible Accounts Report" report, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.

(d) The Contractor shall provide TENNCARE a report, in a format described by TENNCARE, detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due monthly within fifteen (15) business days after the end of the month.

Failure to report outstanding checks to TENNCARE as described above may result in liquidated damages as described in Section 4-8 of this Agreement.

2-10.f. Monthly Activity Reporting

The CONTRACTOR shall provide electronic monthly activity reports to TENNCARE that include the following:

1. MEMBER SERVICES CALL REPORTING:

a. Call Answer Timeliness Rate: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the month/quarter. Calls where the member called directly into member services or selected a member services option and was put in the call queue. Please include detailed rate calculation.

b. The average wait time spent in queue for members calling the member services call center(s)

c. Call Abandonment Rate: 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 CONTRACTOR's member services call center as (during member services open hours of operation) during the month/quarter. Calls where the member called directly into member services or selected a member services option and was put in the call queue.

2. UTILIZATON MANAGEMENT CALL REPORTING:

a. Provider Call Answer Timeliness: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's utilization management call center(s) (during hours of operation) during the month/quarter. Calls where the provider called directly into utilization management or selected a utilization management option and was put in the call queue. Please include detailed rate calculation.

b. The average wait time spent in queue for providers requesting prior authorization.

c. Provider Call Abandonment Rate: 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 CONTRACTOR's utilization management call center as (during open hours of operation) during the month/quarter. Calls where the provider called directly into utilization management or selected a utilization management option and was put in the call queue.

d. Number of provider complaints received, either in writing or by phone during the month/quarter.

The minimum data elements and required format for the reports can be found in Attachment XII, Exhibit I of this Agreement.

2-10.g. Network Clearing House Reporting

The CONTRACTOR agrees to participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a clearinghouse of information. The information to be reported shall include, but is not limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each managed care organization.

2-10.g.1. Eligibility Web Site

TENNCARE will develop and implement a secure and enhanced eligibility web site. The goal will be to make the site available on a seven (7) day a week, twenty four hour (24) a day basis to stakeholders, TennCare Bureau, CONTRACTORS, PCP providers, specialists, facilities and members to access appropriate member information including member eligibility, certain agreed upon demographic information and care management status. The exact data elements, procedures for updating such data and security mechanisms will be defined in a series of joint application design sessions between several cross-functional teams from all stakeholders or their representatives. To make such a site useful, an initial database load and periodic updates will be necessary from the source system available from each stakeholders organization. Agreements will be put in place assuring full participation.

2-10.g.2. Claims Payment Status Web Site

At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TENNCARE in any manner necessary in order to assure that certain claims payment eligibility information can be accessed via the Internet. At TENNCARE's request, the CONTRACTOR shall submit to TENNCARE for approval a plan that outlines educational activities undertaken by the CONTRACTOR to encourage and facilitate provider use of electronic billing. This provision shall not be construed to imply that TENNCARE will require all educational activities be approved by TENNCARE.

2-10.g.3 Community Health Record for TennCare Enrollees (Electronic Medical Record)

At such time that TennCare requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable timeframe, an accessible electronic Community Health Record for TennCare enrollees. The electronic health record format and design will comply with HIPAA regulations. Access to information will vary based on the specific user.

The web site design will take into account recent HIPAA legislation and all such concerns providing security mechanisms that will vary based on the specific user. All information will conform to standards for electronic datasets as defined by HIPAA, as they become available.

2-10.h. Financial Reporting

The CONTRACTOR shall adhere to the financial requirements described in this agreement and shall report all financial information consistent with the requirements described in this Agreement including but not limited to the following:

2-10.h.1. Financial Plan and Projection of Operating Results

By no later than thirty (30) days after the CONTRACTOR goes to a capitated risk model, and then by no later than December 31 of each year thereafter, the CONTRACTOR shall submit to TDCI an annual budget projecting revenues earned and expenses incurred on a calendar year basis through its participation in the State of Tennessee's TennCare Program. 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. By no later than July 31st of each year, the CONTRACTOR shall submit to TDCI a mid-year comparison of actual revenues and expenses to budgeted amounts. 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.

2-10.h.2. Annual Report

The CONTRACTOR shall file with the Tennessee Department of Commerce and Insurance, TennCare Division, a report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations, on or before March 1 of each calendar year, which report is currently required to be filed by all licensed health maintenance organizations pursuant to Tennessee Code Annotated 56-32-208. This annual report shall also 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 State of Tennessee's TennCare Program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of the Tennessee Department of Commerce and Insurance related to the preparation and filing of this report. This annual report will also be accompanied by the Medical Services Monitoring report, where applicable, completed on a calendar year basis. CONTRACTOR shall submit a reconciliation of the Medical Services Monitoring report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).

2-10.h.3. Quarterly Reports

The CONTRACTOR shall file with the Department of Commerce and Insurance, TennCare Division, a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These quarterly reports shall be filed 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) of each calendar 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 State of Tennessee's TennCare program. The second quarterly report shall include the Medical Services Monitoring 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 Services Monitoring report to the second quarterly NAIC report.

2-10.h.4. Audit of Business Transactions

The CONTRACTOR shall also 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 National Association of Insurance Commissioners Annual Statement Instructions regarding the Annual Audited Financial Report. There are 3 exceptions to the aforementioned statement instructions:

(a) The CONTRACTOR shall submit to the Tennessee Department of Commerce and Insurance, TennCare Division, the audited financial statements covering the previous calendar year by May 1 of each calendar year.

(b) 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."

(c) The audit report shall include an income statement addressing the TennCare operations of the CONTRACTOR.

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 the TennCare Agreement, the TennCare Agreement takes precedent. These financial reporting requirements shall supersede any other reporting requirements required of the CONTRACTOR by the Tennessee Department of Commerce and Insurance, and the Tennessee Department of Commerce and Insurance shall enact any necessary rule or regulation to conform to this provision of the Agreement.

2-10.i. Reporting CONTRACTOR Administrative and Staffing Information

The CONTRACTOR shall report administrative and staffing information to TENNCARE as described in Section 2-9.c of this Agreement, including but not limited to the following:

2-10.i.1. Non-discrimination Compliance

Non-discrimination Compliance reporting shall be in a format described and/or agreed upon by TENNCARE and shall be consistent with the requirements set forth in Section 2-24 of this Agreement;

2-10.i.2. Contact Persons

The CONTRACTOR shall identify staff to TENNCARE as described in Section 2-9.c of this Agreement.

2-10.i.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.

Upon request by TENNCARE, the CONTRACTOR shall report to TENNCARE any information requested to verify compliance with the requirements in Section 2-9.c, 2-24 or elsewhere in this Agreement.

Failure to report staffing information, as required by TENNCARE, may result in the application of liquidated damages as described in Section 4-8 of this Agreement.

2-10.j. Medical Services Monitoring Report

Medical Services Monitoring Report shall be submitted monthly with cumulative year to date calculation using the forms in Attachment XII, Exhibit J. The CONTRACTOR shall report all medical expenses relative to the Medical Services Budget Target established by TENNCARE and complete the supporting claims lag tables. Monthly expenditures shall be reported on a rolling basis by provider groupings including but not limited to (i) direct payment to providers for covered medical services, (ii) capitated payments to providers and (iii) subcontractors for covered medical services. The CONTRACTOR will submit these reports monthly, due by the 21st of the following month. 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 will 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.

2-10.k. FQHC Reporting

In accordance with the HCFA Terms and Conditions to the TennCare Waiver, FQHC reporting information shall be submitted to TENNCARE in hard copy on an annual basis using the form in Attachment XII, Exhibit K. This annual report shall be due by January 1 each year.

2-10.l. Business Continuity and Disaster Recovery Reports

The CONTRACTOR shall submit a high level summary of their baseline *Business Continuity and Disaster Recovery (BC-DR)* plan or make it available at CONTRACTOR's local Tennessee site for review and approval as specified by TENNCARE. The CONTRACTOR shall communicate a high level summary of proposed modifications to the BC-DR plan or make it available at CONTRACTOR's local Tennessee site at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and approval by TENNCARE.

2-10.m. Quality Improvement Reports

2-10.m.1. Annual Review and Approval of the Quality Improvement Program

The CONTRACTOR must submit to TENNCARE an approved (by the CONTRACTOR's QI Committee) copy of the Annual Evaluation of the QI Program, a revised Quality Improvement Program Description and companion Work Plan, annually by April 15th . This report shall be submitted electronically.

2-10.m.2. Quarterly Quality Improvement Activities Update

The CONTRACTOR shall update and submit quarterly the Quality Improvement Activities Update Grid along with a brief narrative and barrier analysis explaining any delays encountered for any of the planned activities and the plan for completing any delayed scheduled activities. This report shall be submitted electronically.

2-10.m.3. PCP Assignment

The CONTRACTOR shall submit a quarterly report to TENNCARE by PCP that shall include the following information for non-dual populations: 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 +.

2-10.m.4. Quality Improvement Reporting

Results for quality indicators, including audited CAHPS and HEDIS results are to be submitted to TENNCARE by June 15th annually.

Updates for Disease Management Programs, the three (3) clinical and two (2) service quality improvement activities shall be submitted to the State as part of the quarterly quality update. A brief narrative for each of these activities, delineating specific activities which occurred during the reporting period, should be included. This report shall be submitted electronically.

2-10.m.5 EPSDT Reporting

The CONTRACTOR shall submit a completed quarterly EPSDT Report utilizing the form provided within ATTACHMENT XII, Exhibit H.3. This report shall be submitted electronically.

2-10.m.6 NCQA Accreditation Status Update

The CONTRACTOR shall submit its NCQA Accreditation Report immediately upon receipt, not to exceed ten (10) calendar days from notification by NCQA.

2-10.m.7. Disease Management Evaluation

(a) The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program as described in Section 2-3.s.6, 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.

(b) Annually on July 1st, the CONTRACTOR shall submit a *Disease Management Report* that includes, the following:

(1) Definition of target population (eligibility criteria) for each program and the method used to identify and enroll members including frequency of systematic identification process;

(2) Written description of the stratification levels for each of the four (4) programs , including member criteria and associated interventions;

(3) Information specified in 2-3.s.6 (g);

(4) Written analysis of data presented;

(5) Discussion of barriers and challenges to include resources, program structure, member involvement and provider participation;

(6) Summary of member satisfaction with the DM program; and

(7) Description of proposed changes to program based on evaluation.

2-10.m.8. Outlier Reporting

The CONTRACTOR shall analyze outlier data and report back to TENNCARE their findings. The CONTRACTOR shall assess the prescribing practices of all contracted providers and report back to the Bureau regarding their findings. The report will either provide assurance that the prescriber appears to be practicing their specialty in accordance with acceptable standards of care or will provide a plan to address any identified concern. At a minimum, TENNCARE shall provide the CONTRACTOR a semiannual report listing TennCare providers who appear to be outliers with regard to the numbers and percentages of narcotic prescriptions they write. All such reports shall be due back to TENNCARE within thirty (30) calendar days of the date that TENNCARE provides the CONTRACTOR with the request, unless TENNCARE's request provides for a longer response time.

2-10.m.9. Case Management Reporting

(1) The CONTRACTOR shall submit a quarterly case management report 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 services.

(2) By August 15, 2007, the CONTRACTOR will submit a report to TENNCARE describing the CONTRACTOR's case management services. The report will 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.

2-10.n Cost and Utilization Summaries

The CONTRACTOR shall provide the reports specified below separately for each of the following populations on a quarterly basis for services paid during the previous quarter:

(1) Medicaid;
(2) Uninsured;
(3) Uninsurable/Medically Eligible;
(4) Disabled; and
(5) Duals.

2-10.n.1 Prescription Drug Summary

The CONTRACTOR shall provide a listing of the top 25 prescription drug therapeutic classes by amount paid on a quarterly basis. These reports shall include the following data elements (does not apply to dual eligibles). Effective July 1, 2003, pharmacy services shall be covered by a TennCare contracted pharmacy benefits manager (PBM). However, these reports shall be required to continue until such time as all claims processed are reported by the CONTRACTOR or its subcontracted pharmacy benefits manager (PBM):

1. Rank
2. Therapeutic Class Name
3. Quantity Dispensed (e.g., 1 tube, 100 pills, 1000 ml., etc.)
4. Number of Prescriptions Filled
5. Dispensing Fee
6. Ingredient Cost
7. Total Amount Paid for Each Therapeutic Class
8. Amount Paid as a Percentage of Total Drug Payments

2-10.n.2 Top 25 Providers by Amount Paid

The CONTRACTOR shall provide a summary listing of the top 25 providers by amount paid on a quarterly basis. These reports shall include the following data elements:

1. Rank
2. Provider type
3. Provider Name
4. Street Address (Physical Location)
5. City
6. State
7. Zip Code
8. Amount Paid to Each Provider
9. Amount Paid as a Percentage of Total Provider Payments

2-10.n.3 Top 25 Inpatient Diagnoses by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 25 most frequent inpatient diagnosis based on: (1) number of admissions; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

(a) By Number of Admissions -
1. Rank
2. DRG Code (Diagnosis Code)
3. Description
4. Amount Paid
5. Admits
6. Admits as a Percentage of Total Admits

(b) By Amount Paid -
1. Rank
2. DRG Code (Diagnosis Code)
3. Description
4. Admits
5. Amount Paid
6. Amount Paid as a Percentage of Total Inpatient Dollars

2-10.n.4 Top 25 Outpatient Diagnoses by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 25 most frequent outpatient diagnoses based on: (1) number of visits; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

(a) By Number of Visits -
1. Rank
2. Diagnosis code
3. Description
4. Amount Paid
5. Visits
6. Visits as a percentage of Total Outpatient Visits

(b) By Amount Paid -
1. Rank
2. Diagnosis Code
3. Description
4. Visits
5. Amount Paid
6. Amount Paid as a Percentage of Total Outpatient Payments

2-10.n.5 Top 10 Inpatient Surgical / Maternity Procedures by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 10 most frequent inpatient surgical/maternity DRGs based on: (1) number of admissions; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

(a) By Number of Admissions -
1. Rank
2. DRG Code
3. Description
4. Amount Paid
5. Number of Admissions
6. Admissions as a Percentage of Total Admissions

(b) By Amount Paid
1. Rank
2. DRG Code
3. Description
4. Number of Procedures
5. Amount Paid
6. Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

2-10.n.6 Top 10 Outpatient Surgical /Maternity Procedures by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 10 most frequent outpatient surgical/maternity procedures based on: (1) number of procedures; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

(a) By Number of Procedures -
1. Rank
2. Procedure Code
3. Description
4. Amount Paid
5. Number of Procedures
6. Procedures as a Percentage of Total Surgical/Maternity Procedures

(b) By Amount Paid -
1. Rank
2. Procedure Code
3. Description
4. Number of Procedures
5. Amount Paid
6. Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

2-10.n.7 High-Cost Claimants

The CONTRACTOR shall identify and report to TennCare the number of enrollees who incurred claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis. The CONTRACTOR shall report the enrollee's age, sex, primary diagnosis, and

amount paid by claim type for each enrollee. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.

2-10.o. Cost and Utilization Reports

The CONTRACTOR shall report Cost and Utilization information by TennCare enrollee eligibility category as described in Attachment XII, Exhibits L.1 through L.5 and as required below. CONTRACTOR shall submit a written explanation for how service data will be mapped to the categories identified in said Exhibits by August 1, 2002. These reports shall be maintained in an Excel spreadsheet format and shall be sent via e-mail to TENNCARE on a quarterly basis, based on incurred date, 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.

1. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Cumulative Year to Date" basis.

2. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Rolling Twelve (12) Month" basis. Please note that the aggregated payment information of these reports for certain reporting periods should be reasonably tied the CONTRACTOR's MSBT reports, and invoices/encounters submitted by the CONTRACTOR for the comparable periods.

2-10.p. Network Management

2-10.p.1 PCP Visits

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.

2-10.p.2 Out-of-Network Utilization

As specified in Section 2-9.n, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of utilizing non-network providers. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis.

2-10.p.3 Emergency Room Utilization

As specified in Sections 2-3.s.5 and 2-9.n, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of use of the emergency room and shall submit the following reports regarding Emergency Room/Emergency Department Utilization.

(a) The CONTRACTOR shall submit a monthly 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.

(b) In accordance with Section 2-3.s.5, the CONTRACTOR shall submit to TENNCARE the following Emergency Department Utilization Reports:

(1) No later than February 28th and August 31st each year, submit a report identifying enrollees who exceeded the defined threshold for ED usage and specifying the interventions initiated for each enrollee.

(2) By August 1, 2007, the CONTRACTOR must submit a written report to TENNCARE providing the telephone number that will be used for such scheduling assistance 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.

(3) On a quarterly basis, the CONTRACTOR shall report 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 enrollee, 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 2-9.c.8 of this Agreement.

2-10.p.4 Specialty Utilization

As specified in Section 2-9.n, the CONTRACTOR shall maintain a procedure to identify utilization of specialists by Primary Care Provider enrollee panel. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis.

2-10.p.5 24/7 Nurse Triage Call Line

In accordance with Section 2-9.c.8 of this Agreement, the CONTRACTOR shall track and report on a quarterly basis 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 2-3.s.5 (h) of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-3.s.5 (j) of this Agreement

2-10.q HIPAA Reporting

As described in Sections 2-3.w and 2-10.a, the CONTRACTOR shall transmit/receive from/to 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 a long as TENNCARE direction does not conflict with the law.

Further, the CONTRACTOR shall report to TENNCARE any use or disclosure of information not provided for by this Agreement of which it becomes aware.

Failure to comply with HIPAA reporting requirements may result in the application of liquidated damages as described in Section 4-8 or termination of this Agreement as described in Sections 2-3.w and 4-2 of this Agreement.

2-10.r. Prior Authorization Reporting

On a monthly basis, the CONTRACTOR shall provide a summary of all requests for prior authorization by type of service (e.g., Inpatient, Home Health, Pharmacy, Therapy, Durable Medical Equipment, etc.) received in the preceding month that will include, at a minimum, the following information:

- Total number of requests for prior authorization received;
- Total number of requests for prior authorization processed;
- Total number of requests approved; and
- Total number of requests denied, sub categorized by denial reason [e.g., 10 total denied, 5 – denied for member not eligible, 3 – denied….., etc.(list very specific denial reasons)].

Effective July 1, 2003, Pharmacy services shall be provided by a TennCare contracted pharmacy benefits manager (PBM). At such time, all authorization requests shall be directed to and reported by the TennCare PBM.

This information shall be reported on an Excel file in the format acceptable to TENNCARE and shall be sent to TENNCARE electronically. Failure to provide monthly reports of authorization activities, as specified above, shall result in the application of liquidated damages as described in Section 4-8 of this Agreement.

2-10.s Subcontracted Claims Processing Report

Where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to the TennCare Bureau 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 20% of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually as a Contract Deliverable on May 1 for the preceding year operations or portion thereof. 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:

1. General Controls
   - Personnel Policies
   - Segregation of Duties
   - Physical Access Controls
   - Hardware and System Software
   - Applications System Development and Modifications
   - Computer Operations
   - Data Access Controls
   - Contigency and Business Recovery Planning

2. Application Controls
   - Input
   - Processing
   - Output
   - Documentation Controls

2-11. Accounting Requirements

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.

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.

2-12. Availability of Records

2-12.a. The CONTRACTOR shall insure 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 though TennCare, that TENNCARE representatives and authorized federal, state and Comptroller

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 (HHS 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 the medical care or services provided to TennCare enrollees.

2-12.b. 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 though TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, 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 HHS 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. All records to be sent by mail will be sent to TENNCARE within twenty (20) working 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 HHS 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.

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, HHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, MFCU, HHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

2-12.c. 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 HHS 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:

2-12.c.1. Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or sub-contractor, 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 HHS OIG, and the Office of the Comptroller and any duly authorized governmental agency..

2-12.c.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.

2-12.c.3. Allowing for periodic review to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs have been incurred in accordance with this Agreement, including the requirement that provider reimbursement rates, reimbursement policies/procedures, medical management policies and procedures and Subcontractor arrangements remain in effect as they existed on April 16, 2002, as specified in Section 2-9. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.

2-12.c.4. 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 persons, or organization to conduct the audits.

2-13. 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 1-5 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 HHS 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.

2-14. Independent Review of the CONTRACTOR

In accordance with Chapter 4 of the waiver approved by the Centers for Medicare and Medicaid Services (CMS), CMS may select a PRO, Private Accreditation Organization or an External Quality Review Organization (EQRO) to provide a periodic or an annual independent review of the CONTRACTOR. The results of the review shall be provided to TENNCARE and to the CONTRACTOR and shall be available, on request, to the Department of Health and Human Services, the Office of Inspector General and General Accounting Office. TENNCARE shall be responsible for issuing the Request For Proposal (RFP) and selecting the PRO or EQRO.

2-15. 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 plan. The monitoring shall occur periodically during the Agreement period and may include announced or unannounced visits, or both.

2-16. Changes Resulting from Monitoring and Audit

The CONTRACTOR shall, as soon as is practical and no later than sixty (60) calendar days after a notice of deficiencies is received, unless justified and agreed upon by TENNCARE, comply with all recommendations made in writing by TENNCARE, pursuant to Agreement items found not in compliance as a result of any day to day monitoring activities or any other authorized monitoring report or audit. A written plan to correct cited deficiencies and a time frame for completion of said plan must be submitted to TENNCARE by the CONTRACTOR within fifteen (15) working days after receipt of notice of deficiencies or as soon as practical, whichever is the lesser. TENNCARE may extend or reduce the time frame for corrective action where, in its opinion, it is reasonable and advisable to do so. The CONTRACTOR shall be responsible for assuring corrective action when a subcontractor's or provider's quality of care is inadequate. TENNCARE reserves the right to suspend enrollment in the plan if it is determined that quality of care is inadequate.

In the event the CONTRACTOR fails to complete the actions required by the corrective action plan within the time frame specified, the CONTRACTOR agrees that TENNCARE shall assess the liquidated damages and/or intermediate sanctions as specified in Section 4-8 of this Agreement, or if the deficiencies are severe, that TENNCARE may terminate the Agreement for cause as described in Section 4-2 of this Agreement. The CONTRACTOR further agrees that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days of notice of damages and if payment is not made by the due date, said liquidated damages may be withheld from future fixed administrative fee payments by TENNCARE without further notice.

This Section shall apply to any corrective action requirements not otherwise specifically addressed.

2-17. Subcontracts

a. Subcontract Relationships and Delegation. If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

1. The CONTRACTOR shall evaluate the prospective subcontractor’s ability to perform the activities to be delegated.

2. The CONTRACTOR shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate.

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 or State MCO laws and regulations.

4. The CONTRACTOR shall identify deficiencies or areas for improvement and the CONTRACTOR and the subcontractor shall take corrective action as necessary.

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 2-18 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

b. Legal Responsibility. The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the health plan covered thereunder including all subcontracts/subcontractors. The CONTRACTOR shall assure 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 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 assure that all activities under this Agreement are carried out.

c. Prior Approval. All subcontracts and revisions thereto, as defined in Section 1-3 of this Agreement, shall be approved in advance by TENNCARE. All subcontracts shall be maintained in accordance with the applicable terms of this Agreement, including but not limited to, Sections 2-8, 2-11, 2-12, 2-13, 2-15, 2-16, 4-1, 4-7 and 4-21 of this Agreement. 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) days of execution.

d. Quality of Care. If the subcontract is for the purpose of securing the provision of enrollee benefits, the subcontract must specify that the subcontractor adhere to the Quality requirements the CONTRACTOR is held to.

e. Children in State Custody. The CONTRACTOR must include in its subcontracts and agreements with providers a provision that states that subcontractors and providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TENNCARE.

f. Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions. The CONTRACTOR shall provide instruction for all direct service sub-contractors regarding the CONTRACTOR's written procedure 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.

g. Assignability. Upon the next renewal of existing transportation and claims processing subcontracts or upon execution of transportation and claims processing subcontracts, said subcontract agreements must include language that requires 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.

h. Claims Processing. 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 pharmacy (effective July 1, 2003 TENNCARE shall contract directly with a PBM for the provision of pharmacy services as described in Section 2-3.a.1), vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services.

Where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to the TennCare Bureau 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 20% of TennCare medical expenses of the CONTRACTOR. This report shall be provided in accordance with Section 2-10.s of this Agreement.

i. HIPAA Requirements. The CONTRACTOR shall require all its subcontractors adhere to the HIPAA regulation requirements.

j. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) days prior written notice of the termination to TENNCARE and the TennCare Division, TDCI. Such notice 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, as well as any other pertinent information that may be needed. In addition to prior written notice, the CONTRACTOR shall also provide TENNCARE with a transition plan upon request. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Section 4-8 of this Agreement. TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval. Finally, this subsection does not relieve CONTRACTOR of any responsibilities to submit all proposed material modifications of the MCO operations to TDCI TennCare Division for prior review and approval as required by Title 56, Chapter 32, Part 2.

k. The CONTRACTOR shall not delegate responsibility for any administrative function being conducted directly by the CONTRACTOR as of April 16, 2002 or enter into any Subcontract agreement after April 16, 2002 without the prior written approval of TENNCARE. The CONTRACTOR shall freeze Subcontractor reimbursement rates at the rate being paid and in accordance with the methodology in place as of April 16, 2002 and shall require that Subcontractors freeze reimbursement rates at the rate being paid as of April 16, 2002 for services related to this Agreement. Further, the CONTRACTOR shall implement, and shall require all Subcontractors to implement changes in reimbursement rates as required by TENNCARE.

l. Notice of Approval. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing.

m. Compensation for Utilization Management Activities. Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall assure, consistent with 42 CFR 438.6(h) and 42 CFR 422.208, 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).

2-18. Provider Agreements

The CONTRACTOR shall provide or assure the provision of all covered services specified in Section 2-3.a of this Agreement. The CONTRACTOR may provide these services directly or may enter into agreements with providers and provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment by the CONTRACTOR for services rendered.

The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or S-Chip programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program.

Except for agreements described herein, provider agreements do not require prior approval by TENNCARE before taking effect. Only those provider agreements described below shall require prior approval by TENNCARE: any revision to reimbursement rate and/or methodology, all new or revised facility agreements, and all agreements with providers whose contract status changed from contracted to non-contracted then back to contracted with an increase in reimbursement from the prior agreement. All single case agreements shall be reported to TENNCARE; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears case agreements are being used to circumvent the "new contract review and approval process". All template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMOs certificate of authority (COA) and any material modifications thereof.

The CONTRACTOR shall freeze provider reimbursement rates at the rate being paid as of April 16, 2002, subject to updates per established reimbursement policies and procedures in place, and negotiate changes in reimbursement rates as required by TENNCARE.

All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirement: (No other terms or conditions agreed to by the CONTRACTOR and provider shall negate or supersede the following requirements.)

2-18. a. 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.

2-18. b. Specify the effective dates of the provider agreement;

2-18. c. Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

2-18. d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the CONTRACTOR;

2-18. e. Identify the population covered by the provider agreement;

2-18. f. 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. The CONTRACTOR may require that a TennCare Standard adult pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. 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;

2-18. g. 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;

2-18. h. Specify the amount, duration and scope of services to be provided by the provider and inform provider of TennCare non-covered services as described in Section 2-4 of this Agreement and the TennCare rules and regulations at 1200-13-13-.10 and 1200-13-14.10;

2-18. i. Provide that emergency services be rendered without the requirement of prior authorization of any kind;

2-18. j. Specify unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the network provider's contract with the CONTRACTOR and include definition of unreasonable delay as described in Section 2-3.r.1.

2-18. k. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that HCFA mandates the enforcement of the provisions of CLIA;

2-18. l. Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the agreement 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 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).

All agreements shall include a statement that as a condition of participation in TennCare, enrollees shall give the TENNCARE Bureau, TENNCARE, the Office of the Comptroller, and any health oversight agency, such as OIG, MFCU, HHS 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 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 HHS OIG and the DOJ.

Require that medical records requirements found in Section 2-9.i be included in provider agreements and that medical records be maintained at site where medical services are rendered. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When 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 case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

The provider agreement must contain the language described in Section 2-12 and 2-13 of this Agreement;

2-18. m. Provide that TENNCARE, U.S. Department of Health and Human Services, and Office of Inspector General 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 PHI to health oversight agencies, including, but not limited to, OIG, MFCU, HHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, MFCU, HHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

2-18. n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees sponsored by the CONTRACTOR;

2-18. o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the CONTRACTOR and/or TENNCARE;

2-18. p. Specify CONTRACTOR's responsibilities under its participation agreement, including but not limited to, provision of a copy of the member handbook whether via web site or otherwise and requirement that CONTRACTOR notice a provider of denied authorizations;

2-18. q. Specify that the CONTRACTOR shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

2-18. r. Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

2-18. s. Provide for submission of all reports and clinical information required by the CONTRACTOR;

2-18. t. Provide the name and address of the official payee to whom payment shall be made;

2-18. u. Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;

2-18. v. Provide for prompt submission of information needed to make payment. Specify that a provider shall have at least, but no more than one hundred and 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 plan 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 plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility;

2-18. w. 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 T.C.A. 56-32-226 and Section 2-9.m. of this Agreement;

2-18. x. 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 payor) 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 patient being served;

2-18. y. For those agreements where the provider is compensated via a capitation arrangement, language which requires that, if provider becomes aware for any reason that s/he 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. If such notification is not made within thirty days of the provider's knowledge, s/he may be subject to the sanctions set forth elsewhere in this Agreement;

2-18. z. Require the provider to comply with fraud and abuse requirements described in Section 1-5 of this Agreement;

2-18. aa. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the CONTRACTOR under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

2-18. bb. Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan. Provide that the agreement incorporates by reference all applicable federal and state laws, TennCare rules and regulations or court orders, and revisions of such laws or regulations shall automatically be incorporated into the agreement, as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the CONTRACTOR and provider agree to negotiate such further amendments as may be necessary to correct any inequities;

2-18. cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the 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 agreement, then the terms must include provisions allowing at least thirty (30) 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);

2-18. dd. 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 4-2 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 MCO/provider agreement. The provision of such records shall be at no expense to TENNCARE;

2-18.ee. 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 MCO as provided at T.C.A. 56-32-226(b).

2-18. ff. Include a conflict of interest clause as stated in subsections (a) and (c) of Section 4-7, Gratuities clause as stated in 4-11 and Lobbying clause as stated in 4-12 of this Agreement between the CONTRACTOR and TENNCARE;

2-18. gg. 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 MCO. This indemnification may be accomplished by incorporating Section 4-20 of the TENNCARE/MCO Agreement in its entirety in the provider agreement or by use of other language developed by the MCO and approved by TENNCARE.

2-18. hh. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Section 4-22 of this Agreement;

2-18. ii. Specify the extent to which any savings or loss realized by the plan shall be shared with the providers;

2-18. jj. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and CONTRACTOR to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the CONTRACTOR;

2-18. kk. Specify provider actions to improve patient safety and quality;

2-18. ll. 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:

1. assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review; and
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 when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

2-18. mm. 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 penalties against the provider as appropriate.

2-18. nn. 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 Court Orders. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices;

2-18. oo. All provider agreements must include language which informs providers of the package of benefits that EPSDT (TENNderCare) offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. A listing of the EPSDT benefit package is contained in Attachment IX of this Agreement. All provider agreements must contain language that references the EPSDT (TENNderCare) benefit package found in Attachment IX and the agreement shall either physically incorporate Attachment IX or include language to require that the attachment be furnished to the provider upon request. At the next renewal or amendment period of provider agreements, this Attachment IX shall be deleted and replaced by the new reference and items found in Section 2-3.s.8 of this Agreement;

2-18. pp. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare;

2-18. qq. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

2-18. rr. All primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) and claims for the provision of behavioral health services within CPT code range 96150 through 96155 to the CONTRACTOR for payment; and

2-18. ss. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

2-18. tt. Specify instruction 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.

2-18. uu. 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.

2-18. vv. Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect

The CONTRACTOR shall give TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, immediate notification in writing by Certified Mail of any administrative or legal action or complaint 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.

2-19. Fidelity Bonds and Insolvency Protection

The CONTRACTOR shall secure and maintain during the life of this Agreement any fidelity bonds and/or insolvency protection required by the Tennessee Department of Commerce and Insurance. Proof of coverage must be submitted to TENNCARE as a deliverable item pursuant to Attachment I of this

Agreement within sixty (60) calendar days after execution of this Agreement and prior to the delivery of health care, which ever comes first.

2-20. Insurance

A non-governmental CONTRACTOR shall not commence any work in connection with this Agreement until it has obtained all the insurance coverage required in this Agreement. Nor shall the CONTRACTOR allow any subcontractors or contract providers to commence work on his or her part of the subcontract or provider agreement until all similar insurance required of the subcontractor or provider has been so obtained. The insurance includes but is not limited to general liability, worker's compensation, and medical malpractice insurance. The CONTRACTOR shall furnish proof of coverage of insurance by a certificate of insurance submitted to TENNCARE as a deliverable item pursuant to Attachment I of this Agreement. Governmental CONTRACTORS must meet this requirement in accordance with the specific statutes that apply.

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 providing such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.

Failure to provide proof of coverage within the specified time period may result in this Agreement being terminated.

2-21. Ownership and Financial Disclosure

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General or Centers for Medicare and Medicaid Services, 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 at times and on forms prescribed by the TENNCARE agency, but no less frequently than on an annual basis to be provided no later than March 1 of each calendar year. The following information shall be disclosed:

2-21. a. 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. b. The identity of any provider or subcontractor with whom the CONTRACTOR has had business transactions 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. c. 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. d. Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest.

2-21. e. If the CONTRACTOR is not a federally qualified MCO, the CONTRACTOR shall disclose certain transactions with parties of interest to TENNCARE. Transactions shall be reported according to the following guidelines:

1. The CONTRACTOR shall disclose the following transactions:
   (a) Any sale, exchange or lease of any property between the HMO and a party in interest;
   (b) Any lending of money or other extension of credit between the HMO and a party in interest; and
   (c) 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. The information which must be disclosed in the transactions includes:

   (a) The name of the party in interest for each transaction;
   (b) A description of each transaction and the quantity or units involved;
   (c) The accrued dollar value of each transaction during the fiscal year; and
   (d) Justification of the reasonableness of each transaction.

3. If the contract is being renewed or extended, the CONTRACTOR must disclose information on business transactions which occurred during the prior contract period. If the contract is an initial contract 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.

4. A party in interest is:

   (a) 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 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 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;

   (b) 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 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO;

   (c) Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or

   (d) Any spouse, child, or parent of an individual described in subsections (a), (b), or (c)

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

2-22. Authorized Community Services Area(s)

The State of Tennessee has been divided into twelve (12) geographic areas consisting of one (1) or more counties within a defined geographic area, which correlates to the sources where residents typically receive medical care. These geographic areas have been referred to throughout this Agreement as community service areas (CSA). Enrollees will be enrolled in the CONTRACTOR's plan by CSA's within a Grand Region(s) of the State. The Grand Regions include the CSAs listed below and the specific counties in each CSA are listed in Section 1-3 of this Agreement.

2-22.a. CONTRACTOR's Authorized Service Areas

The CONTRACTOR is specifically authorized by TENNCARE to serve enrollees who reside in one of the following community service area(s) within the Grand Region specified:

East Grand Region		Middle Grand Region		West Grand Region	
___	First Tennessee	___	Upper Cumberland	___	Northwest
___	East Tennessee	___	Mid Cumberland	___	Southwest
___	Knox	___	Davidson	___	Shelby
___	Southeast Tennessee	___	South Central		
___	Hamilton				

TENNCARE shall enroll only persons who reside within the community service area(s) within the Grand Regions in which the CONTRACTOR is authorized to serve as indicated above.

The CONTRACTOR must serve all CSAs in the Grand Region it has been assigned unless the CONTRACTOR was serving only one or more CSA(s) within a Grand Region on July 1, 2000. The CONTRACTOR cannot be closed to enrollment in any CSA in the Grand Region(s) served unless the CONTRACTOR was serving only one or more CSA(s) within a Grand Region on July 1, 2000. If the CONTRACTOR was serving one or more CSA(s) in a Grand Region on July 1, 2000, but did not serve the entire Grand Region on July 1, 2000, at the State's discretion, the CONTRACTOR shall not be required to serve the entire Grand Region. The State has discretion to terminate CONTRACTOR's participation in any Grand Region in which TENNCARE has determined the CONTRACTOR is unable to adequately serve enrollees in compliance with this Agreement.

Any enrollment or marketing outside the approved area(s) must be prior approved by TENNCARE. The provision of services required by Section 2-3 of this Agreement, shall occur within each approved community service area(s) to the extent possible and practical as required by Section 2-3 of this Agreement. If for any reason it is determined by TENNCARE that the CONTRACTOR is not adequately serving one or more authorized community service areas, TENNCARE may, at any time, terminate authorization of the community service area(s) and disenroll the enrollees in the community service area from the health plan. Enrollees shall be transferred as the result of voluntary selection or on a non-discriminatory assignment basis to a TennCare health plan that is authorized to serve the community service area.

To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a community service area of the approved opening, closing or limiting of enrollment of any MCO serving the community service area or Grand Region (as defined below) whichever is applicable; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to comply with the terms of this Agreement.

2-22.b. Expansion of Service Area

The CONTRACTOR may expand service areas by Grand Region with approval of TENNCARE, demonstration of an adequate provider network and written amendment of this Agreement.

If the CONTRACTOR is serving only a portion of a Grand Region, the CONTRACTOR may expand its service area to encompass all community service areas within the entire Grand Region. If the CONTRACTOR is serving an entire Grand Region it may expand its service area to encompass another Grand Region in its entirety.

Grand Region(s) will be assigned to the CONTRACTOR by the State based on:

2-22.b. 1. Request of a Grand Region by the CONTRACTOR; and

2-22.b. 2. Assessment by the State of CONTRACTOR's ability to serve enrollees in the requested region, including network adequacy and administrative infrastructure. This includes but is not limited to review of the adequacy of:

(a) provider networks, including specialists;
(b) network management;
(c) provider standards;
(d) timely provider reimbursement;
(e) member surveys;
(f) staffing ratios;
(g) quality management and utilization management;
(h) encounter data reporting;
(i) financial viability;
(j) claims systems;
(k) information systems;
(l) member services;
(m) accounting;
(n) medical director;
(o) appeals unit;
(p) administrative processes; and

2-22.b. 3. Assessment by the State of the TennCare programmatic needs.

2-22.c. Termination of Community Service Area

If authorization to serve a specific community service area is terminated, regardless of the reason, the CONTRACTOR shall submit a termination plan as specified in Section 4-2.g.10 of this Agreement, specific to the community service area being terminated.

2-23. CONTRACTOR Appeal Rights

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of T.C.A. Section 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 terms and conditions contained within this Agreement pending the final resolution of the contested action.

2-24. Non-Discrimination Compliance

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 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. The CONTRACTOR shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

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.E.. 97-35) the CONTRACTOR shall:

2-24.a. Designate a staff person to be responsible for non-discrimination compliance on behalf of the CONTRACTOR. The designated staff person shall be identified by name in writing to TENNCARE within thirty (30) days of the effective date of this Agreement. The CONTRACTOR does not have to require that non-discrimination compliance be the sole function of the designated staff person.

2-24.a.1. In respect to any period of time that the CONTRACTOR does not have a designated staff person responsible for non-discrimination compliance it shall be reported 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 such period of time. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported to TENNCARE, to the attention of the Director of Non-discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the change.

2-24.b. The CONTRACTOR shall develop written policy and 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. The CONTRACTOR's Non-discrimination Compliance Coordinator shall provide instruction for its staff, including but not limited to, all providers and direct service sub-contractors regarding the procedure.

2-24.c. On an annual basis, the CONTRACTOR shall submit a copy of the CONTRACTOR's personnel policies that, at a minimum; emphasize non-discrimination in hiring, promotional, operational policies, contracting processes and participation on advisory/planning boards or committees.

2-24.d. On a quarterly basis, the CONTRACTOR shall submit a summary listing totaling the number of supervisory personnel by race/national 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. Such listing shall separate categories for total supervisory personnel by; 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/national origin as indicated by staff 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/national origin females as indicated by staff.

2-24.e. On an annual basis, the CONTRACTOR shall submit a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin (to be indicated as in Section 2-24.d) and shall be sorted by CSA. Each provider type (e.g., physician, dentist, etc.) shall be reported separately within the CSA. Primary care providers shall be reported separately from other physician specialties. The CONTRACTOR is required to request this information from all providers. 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.

2-24.f. On a quarterly basis, the CONTRACTOR shall submit a listing of all complaints alleging discrimination filed by employees (when the complaint is related to TennCare benefits provided by the CONTRACTOR), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare Plan. 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, CONTRACTOR's resolution, if resolved, and name of CONTRACTOR staff person responsible for adjudication of the complaint.

2-24.g. On a quarterly basis, a listing of all requests for translation/interpretation services by requesting enrollee.

2-24.g.1. Each request reported will identify by name and member identification number the enrollee for which translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.

2-24.h. On an annual basis, a copy of the CONTRACTOR's policy, that demonstrates non-discrimination in provision of services to persons with Limited English Proficiency.

2-24.h.1. A listing of the interpreter/translator services utilized by the CONTRACTOR in providing services to enrollees with Limited English Proficiency. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.

2-24.i. On an annual basis, the CONTRACTOR's Title VI Compliance Plan and Assurance of Non-discrimination. The signature date of the CONTRACTOR's Title VI Compliance Plan is to coordinate with the signature date of the CONTRACTOR's Assurance of Non-discrimination Compliance.

2-25. Notice of Legal Action

The CONTRACTOR shall provide to TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, notice 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. 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.

2-26. Prohibition of Illegal Immigrants.

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.

a. 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 II, 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.

b. 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.

c. 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.

d. 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.

e. 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.

SECTION 3 - TENNCARE RESPONSIBILITIES

3-1. General Responsibilities

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 U.S.C. Section 1396a(a)(19).

The State shall review and may require modifications to all policies related to the implementation of this Agreement, including provider reimbursement rates. 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 in writing. The State will then respond in writing making a determination within thirty (30) days. The CONTRACTOR shall then act in accordance with such policy determinations and/or operating guidelines.

3-2. Eligibility Determination

The State shall have sole responsibility for determining the eligibility of an individual for TennCare funded services. Nonetheless the CONTRACTOR shall not cause to be submitted to TENNCARE applications for enrollment for persons that the CONTRACTOR knew or reasonably should have known were ineligible pursuant to Section 1-6 of this Agreement.

3-3. Approval Process

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. Should TENNCARE not respond in the required amount of time, as set forth in Attachment I, 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. Material requiring TENNCARE approval includes, at a minimum, the following:

3-3.a. Fraud and Abuse Compliance Plan;

3-3.b. Provider network;

3-3.c. Marketing and/or enrollee plans, materials and all related materials to be used in soliciting enrollment, educating or communicating with existing enrollees;

3-3.d. Drug formulary and all subsequent changes (applicable only if a closed formulary). Effective July 1, 2003, TENNCARE shall contract directly with a pharmacy benefits manager (PBM) for the provision of pharmacy services as described in Section 2-3.a.1 of this Agreement;

3-3.e. Subcontracts;

3-3.f. Indemnity language in provider agreements if different than standard indemnity language found in Section 4-20 of this Agreement;

3-3.g. Quality Monitoring/Quality Improvement procedures;

3-3.h. Insurance and bonding plans;

3-3.i. Alternative method of lock-in restriction procedures;

3-3.j. MCO/BHO Coordination Agreement;

3-3.k. Termination Plan;

3-3.l. For the purpose of non-renewal by the CONTRACTOR or by TENNCARE, as provided at Section 4-2.f of this Agreement, written Binding Guarantee from a financially viable entity of all debts incurred in the amount of $4.5 million or the minimum net worth required to be maintained by a health maintenance organization operating under a Certificate of Authority in the State of Tennessee, whichever is greater;

3-3.m. Any changes to provider or subcontractor reimbursement rates and reimbursement methodologies in effect April 16, 2002 and all inpatient facility agreements; and

3-3.n. Any changes in Medical Management Policies and Procedures as defined in Section 1-3.

3-4. Interpretations

Any dispute between the CONTRACTOR and TENNCARE concerning the clarification, interpretation and application of all federal and state laws and regulations governing or in any way affecting this Agreement shall be determined by TENNCARE. When a clarification, interpretation and application is required, the CONTRACTOR will submit written requests to TENNCARE. TENNCARE will contact the appropriate agencies in responding to the request by submitting the written request to the agency within thirty (30) days after receiving that request from the CONTRACTOR. Any clarifications received pursuant to requests for clarification or interpretation 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, and/or policy.

3-5. Facility Inspection

TENNCARE, the Centers for Medicare and Medicaid Services, or their agents 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.

3-6. Monitoring

TENNCARE, in its daily activities, shall monitor various aspects of the CONTRACTOR’s health plan for compliance with the provisions of this Agreement. Further, TENNCARE, the Centers for Medicare and Medicaid Services, or their agents 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. Such monitoring activities shall include, but are not limited to, inspection of CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination, 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. Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis

will be placed on case record validation during periodic monitoring visits to project sites. TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

3-7. Enrollment, Disenrollment and Eligibility Verification

TENNCARE shall be responsible for the receipt of applications for TennCare eligibility, verification of the data contained on the application, determination of the applicability of cost sharing amounts and collection of applicable premiums. TENNCARE shall also be responsible for enrollment of eligible persons in the CONTRACTOR'S plan and for disenrollment of ineligible persons from the CONTRACTOR'S plan. In accordance with federal requirements, if TENNCARE fails to make a decision within the required timeframes, the request shall be considered approved. All TENNCARE approved disenrollment terminations shall be effective on or before the first day of the second month following the month of an enrollee's request to terminate from an MCO. Unless otherwise requested by an enrollee, TENNCARE shall provide for automatic reenrollment of an enrollee who is disenrolled solely because he or she loses eligibility for a period of 2 months or less. TENNCARE will arrange for the CONTRACTOR to have updated eligibility information in the form of on-line computer access and will notify the CONTRACTOR when TENNCARE determines that an enrollee has moved. TENNCARE may provide the CONTRACTOR with a report containing enrollees for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this report, the CONTRACTOR shall provide TENNCARE with any information that is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, proof of uninsurability, including limited coverage and exclusionary riders to policies, change of residence or residence outside the State of Tennessee.

TENNCARE shall not enroll applicants as the result of enrollment applications submitted by a CONTRACTOR or anyone acting on its behalf.

In accordance with Section 2-22 of this Agreement, TENNCARE has authorized the CONTRACTOR to serve one or more community service areas within a Grand Region. TENNCARE shall maintain the flexibility to freeze enrollment, or begin disenrollment in one or more area(s) of the CONTRACTOR's plan if TENNCARE determines it to be in the best interest of enrollees, the CONTRACTOR's plan and/or the TennCare program. However, during such periods that TENNCARE has suspended enrollment in an area(s), TENNCARE shall maintain the flexibility to allow enrollees to continue to be enrolled in such areas when; 1) the enrollee is a member of the same household that is currently in the CONTRACTOR's plan, 2) it is determined necessary by TENNCARE due to an emergent or hardship case, or 3) the enrollee had requested enrollment in the CONTRACTOR's plan prior to closure of additional enrollment.

3-8. Appeal

Enrollees may request state level review of adverse cost-sharing enrollment and financial obligation related decisions to TENNCARE. The state level review will be conducted in accordance with the TENNCARE rules and regulations. The CONTRACTOR is bound by the state level decision.

3-9. Technical Assistance

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE. Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE. Refer to Section 2-9 Part a Subpart 10 regarding TAGS.

3-10. Payments to the CONTRACTOR

3-10.a. The Capitation Rate

Capitation rates shall be paid according to the methodology as described in this Agreement.

In the event that the State elects to carve out a covered benefit, the CONTRACTOR agrees that the capitation payments specified in Attachment X of this Agreement shall be reduced by the amount of the actuarial value for the service to be carved out, as determined by the State's actuary.

3-10.b. Annual Actuarial Study

The State of Tennessee Funding Board, as described in T.C.A. 9-9-101, shall be designated to serve as the official entity to commission an annual actuarial study of the TennCare Program, validate that the Governor's Budget recommendation is consistent with the Actuarial Study and recommend MCO payment methodologies. TENNCARE shall work with the Funding Board to implement recommendations. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE and/or the Funding Board in order to assist the Funding Board in its efforts.

3-10.c. Payment of the Capitation Rate

TENNCARE or its appointed agent shall make payment by the fifth (5th) working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees multiplied by the rate for the enrollee category.

The actual amount owed the CONTRACTOR for each enrollee shall be determined by dividing the appropriate monthly capitation rate category by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan less the withhold amount. 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. 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. TENNCARE shall retroactively adjust the payment to the CONTRACTOR, not to exceed twelve (12) months. TENNCARE and the CONTRACTOR agree that the twelve (12) month limitation described in this paragraph is applicable only to retroactive capitation rate payment adjustments described in this Section and shall in no way be construed as limiting the effective date of eligibility or enrollment in the CONTRACTOR's plan. Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process.

The capitation rate stated will be the amount paid, with the exception of reductions for the withhold Effective July 1, 2000, the capitation rates in effect include a discount for enrollee cost sharing and will not be reduced further for cost sharing.

The CONTRACTOR will be paid the capitation rate for each enrollee based on the enrollee's eligibility rate category and region of residence, both described in Attachment X.A. For the purpose of capitation rates, dual enrollees are TennCare eligibles who have Medicare eligibility. Effective July 1, 2000, the disabled rate is only for those disabled individuals who are Medicaid eligible.

The following shall be applicable to calculating the capitation rate:

3-10.c. 1. The State has the discretion to retroactively adjust the capitation payment for any enrollee if TENNCARE determines an incorrect payment was made to CONTRACTOR; provided, however,

3-10.c.1.(a) In order for the CONTRACTOR to be paid the eligibility rate for TennCare/Dual eligibility, the information indicating that the enrollee is TennCare/Dual eligible must be in the TennCare eligibility system at the time the calculation is made. TENNCARE will not retroactively adjust the capitation payment paid for an enrollee to reflect TennCare/Dual eligibility.

3-10.c.1.(b) For determining the rate only, an enrollee's residence shall be conclusively determined to be the region of residence recorded in the TennCare eligibility system at the time the capitation payment is calculated and the capitation payment shall not be retroactively adjusted to reflect a different region of residence. This provision is applicable only for determination of applicable rate payment and is not applicable to any other consideration, such as applicable plan or duration of enrollment in any plan.

3-10.c.1.(c) For individuals enrolled with a retroactive effective date on the date enrollment, the payment rate for retroactive periods shall be as follows:

3-10.c.1.(c)(1) For MCOs participating in the TennCare Program as of July 1, 2000, the payment rate for the period July 1, 2000 through June 30, 2001, shall be the capitation rate in effect for the period July 1, 2000 through June 30, 2001 for the applicable eligibility rate category and region of residence as specified in Attachment X.B;

3-10.c.1.(c)(2) For MCOs that were not participating in the TennCare Program as of July 1, 2000, the payment rate for the period July 1, 2000 through June 30, 2001, shall be the capitation rate in effect for the period July 1, 2001 through June 30, 2002 for the applicable eligibility rate category and region of residence as specified in Attachment X.B; and

3-10.c.1.(c)(3) The payment rate for retroactive periods prior to July 1, 2000 for all MCOs, regardless of whether they were participating in the TennCare Program during the retroactive period, shall be the statewide average capitation rate for each covered enrollee category in effect during the applicable period as specified in Attachment X.B.

3-10.c.1.(c)(4) 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 X.C). If the CONTRACTOR had a TennCare Bureau approved alternative cost-share schedule in place during this retroactive period of eligibility, the CONTRACTOR may apply its alternative schedule.

3-10.c. 2. The State reserves the unilateral right to revise these rates as described in item (a) below if the State determines a change is necessary to maintain the actuarial integrity of the rate structure.

3-10.c.2.(a) The CONTRACTOR agrees to accept the State's recalibration of rates based upon an adjustment for health plan risk.

3-10.c.2.(a)(1) Health plan risk assessment scores will be initially recalibrated after the close of the Spring 2001 open enrollment choice period for application to payment rates effective on the date enrollment changes become effective.

3-10.c.2.(a)(2) This recalibration will be based upon the distribution of enrollment the first day after completion of the open enrollment choice period and health status information will be derived from encounter data submitted by the CONTRACTOR and the other health plans through the most recent twelve month period deemed appropriate by the State's actuary.

3-10.c.2.(a)(3) An individual's health status will be determined using the Chronic Disease and Disability Payment System (CDPS) software. In the event the State elects to use a different system to calculate an adjustment for health plan risk, the State agrees to provide the CONTRACTOR with an opportunity to review and comment on the proposed system prior to its implementation.

3-10.c.2.(a)(4) The adjustment allowed on the risk adjustment payment rates described in 2(a)(1) and 2(a)(2) above may vary as much as 5% from average, consequently, changes in payment rates resulting from changes in population mix may vary as much as 10.53% of rates displayed in the current calculation.

3-10.c.2.(a)(5) Health plan risk assessment scores will be recalibrated using the same process on an annual basis, following the annual choice period, using updated encounter and eligibility data.

3-10.c.2.(a)(6) 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 a health plan enters or leaves a region. If a plan withdraws from a region, that plan's membership will be distributed to the remaining health plans or to new plans. New risk adjustment values for the remaining plans or new plan(s) will be calculated that consider the population that will be enrolled in the plan for the remainder of the contract year only. In this instance, plans would be given the option to provide TENNCARE, in writing, with a six (6) months notice of termination. This is the only instance when plans would be given the opportunity to give a notice of termination outside of

the provisions in Section 4-2.f. of this Agreement. This notice option is not available for rate adjustments as described in Sections 3-10.b.2.(a)(1) through 3-10.b.2.(a)(5).

3-10.c.2.(a)(7) In the event an annual choice period is postponed or delayed, TENNCARE agrees health plan risk assessment scores will be recalibrated within eighteen months of the last recalibration.

3-10.d. Withhold of the Capitation Rate

The purpose of the withhold is to assure CONTRACTOR compliance with all TENNCARE requirements, including the requirements of Section 2-3 Benefits/Service Requirements and Limitations, Section 2-9.j TennCare Quality Monitoring/Quality Improvement (QM/QI) Program and Attachment II Quality of Care Monitors of this Agreement, by establishing an agreed incentive for assuring CONTRACTOR compliance with the terms of this Agreement. If TENNCARE has not identified CONTRACTOR compliance deficiencies, TENNCARE will pay to the CONTRACTOR the withhold of the plan's payments withheld in the month subsequent to the withhold. The amount of the withhold will be determined as follows:

3-10.d. 1. For MCOs that executed the September 11, 1995 TennCare/MCO Contractor Risk Agreement, the initial withhold amount will be the amount that is currently being applied to the MCO as of June 30, 2001. For all other MCOs, the initial withhold amount will be ten percent (10%) of the monthly capitation payment;

3-10.d. 2. If TENNCARE determines that the CONTRACTOR has no deficiencies for six (6) consecutive months, the monthly withhold amount will be reduced to five percent (5%).

3-10.d. 3. After twelve months, if the CONTRACTOR’s withhold amount was previously reduced to five percent (5%) and no intermediate sanctions, including liquidated damages have been applied to the CONTRACTOR, the monthly withhold amount will be reduced to two and one half percent (2.5%).

3-10.d. 4. If TENNCARE determines that the CONTRACTOR has one (1) or more deficiencies in a given month, the amount of monthly withhold will be ten percent (10%) for each month that a deficiency exists and for six (6) consecutive months after the deficiency is corrected. After six (6) consecutive months with no deficiencies, the monthly withhold amount will again be reduced to five percent (5%) and continue at five percent (5%) as long as no deficiencies are identified. After twelve consecutive months, the withhold may be reduced again as specified in item 3 above. 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.

If TENNCARE has determined the CONTRACTOR is not in compliance in any given month, TENNCARE will provide written notice of such determination and TENNCARE will retain the amount withheld for the month prior to TENNCARE identifying the compliance deficiencies. The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies shall be in accordance with Section 3-10.d.4 as described above. If the CONTRACTOR has attained a two and one half percent (2.5%) withhold and TENNCARE has determined the CONTRACTOR is not in compliance in any given month, TENNCARE will provide written notice of such determination and TENNCARE will re-institute the retention of the withhold as described in Section 3-10.d.4 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 plan 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 plan'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.

3-10.e. Financial Accountability and Risk Arrangements

3-10.e.1. Medical Loss Ratio

The CONTRACTOR is required to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a fiscal year as an accountability measure for through June 30, 2002. At such time as accountability measures are developed, implemented and it is determined by the State that said accountability measures are being met by the CONTRACTOR, the State may eliminate this requirement as an accountability measure for future Fiscal Years. (If CONTRACTOR serves more than one Grand Region, then this 85% medical loss ratio must be met for each Grand Region served.) The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees. Medical expenses for the purpose of this requirement are defined in Section 1-3. The medical loss ratio shall be reported monthly using the cumulative year to date calculation and the Exhibit in Attachment XI. CONTRACTOR shall report all medical expenses and capitation payments received from TENNCARE. Monthly expenditures shall be reported by provider groupings including but not limited to (i) direct payment to providers for covered medical services, (ii) capitated payments to providers and (iii) subcontractors for covered medical services. The CONTRACTOR will submit these reports monthly, due by the 21st of the following month. The CONTRACTOR will 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 be accompanied by a reconciliation to NAIC filings.

The medical loss ratio requirement will be monitored monthly and reconciled annually to determine compliance. In the event CONTRACTOR has not distributed 85% of its capitation rate for any month and it appears that the CONTRACTOR will not ultimately reach its annual target, as determined during monthly monitoring, the STATE may require the CONTRACTOR to submit a corrective action plan in compliance with Section 2-16 above. In addition to the remedies specified in Section 2-16, the STATE

may order CONTRACTOR to distribute to providers the difference between 85% and the percentage distributed including projected distributions for incurred but not reported claims. At such time as accountability measures are developed, implemented and it is determined by the State that said accountability measures are being met by the CONTRACTOR, the State may eliminate this requirement as an accountability measure for future Fiscal Years.

An assessment of CONTRACTOR's medical loss ratio will be made within ninety (90) days of the end of each fiscal year and as otherwise needed for MCOs participating in the optional profit/loss risk banding program to finalize the risk-sharing settlement calculation.

3-10.e.2. Profit/Loss Risk Banding

Any MCO that executed the September 11, 1995 Contractor Risk Agreement, as amended, had the option of participating in a profit/loss risk banding program as described in Section 3-10 of that Agreement. If the Contractor elected to participate in a risk-band option prior to the effective date of this Agreement, the risk band chosen shall be applied according to the terms of the September 11, 1995 Contractor Risk Agreement, as amended. The CONTRACTOR has the option to participate in one of the four profit/loss risk banding options described below. If the CONTRACTOR chooses risk banding Options 1, 2 or 3, it must provide written notice of this choice to the State within seven (7) days of receipt of the recalibrated rates after the Spring open enrollment period in 2001. The CONTRACTOR may not elect to change risk band options for application to retroactive periods. If the Contractor elects Option 1 or 2, the risk band option will be effective from July 1, 2001 through December 31, 2001. The CONTRACTOR may opt to change risk band options a final time by notifying the State in writing no later than December 1, 2001. The subsequent risk band option will be effective January 1, 2002 through June 30, 2002. If the Contractor elects Option 3, the risk band will be effective from July 1, 2001 through June 30, 2002. The risk band options shall be calculated based upon services rendered to enrollees, expenses incurred by the CONTRACTOR, and the revenues received by the CONTRACTOR during the applicable calculation period. If the Contractor elects Option 1 or 2, the risk band option will be calculated for the period of July 1, 2001 through December 31, 2001 and January 1, 2002 through June 30, 2002. If the CONTRACTOR does not provide written notice to the State to change a risk banding option on December 1, 2001, the CONTRACTOR will remain in the risk band option selected for the period July 1, 2001 through December 31, 2001 for the entire period beginning January 1, 2002 and ending June 30, 2002. If the Contractor elects Option 3, the risk band option will be calculated for the period July 1, 2001 through June 30, 2002. TENNCARE reserves the right to modify the optional profit/loss risk banding program prior to the beginning of each contract year with the mutual agreement of the CONTRACTOR. MCOs who choose not to participate in the optional profit/loss risk banding programs are at risk for 100% of any profit or loss resulting from participation in the TennCare program. The CONTRACTOR shall notify the state of its selection in writing in accordance with the timeframes specified above. Calculations showing profit and loss shall be based upon generally accepted accounting principles, shall be submitted to the State within ninety (90) days of the ending settlement periods described herein, and shall be subject to final approval by TENNCARE in the event the profit/loss triggers a sharing of profit/loss under the option selected by the CONTRACTOR. If the CONTRACTOR elects to change risk band options, or changes from assuming full risk to a risk band option, the CONTRACTOR must demonstrate that it has satisfied the MLR requirement for the period prior to the effective date of the risk band option before

completing a calculation showing profit and loss for the purpose of determining risk-sharing amounts.

The following options are available:

Option 1 – Risk-sharing varies dependent upon the percentage above or below total TennCare revenue. TENNCARE and the CONTRACTOR share in all gains and losses as defined below:

Losses: For losses up to 10%, the State will pay for 50% of the loss. For losses in excess of 10%, the State will pay the following percentages of loss:

July 1, 2001 – December 31, 2001	90%
January 1, 2002 – June 30, 2002	80%

Gains: For gains up to 10% of TennCare revenue, the State will be paid 70% of the gain. For gains in excess of 10%, the State will be paid the following percentage of gain:

July 1, 2001 – December 31, 2001	90%
January 1, 2002 – June 30, 2002	80%

Option 2 – Risk-sharing varies dependent upon the percentage above the medical loss ratio. The CONTRACTOR is responsible for the first two percent (2%) of medical costs, regardless of profit or loss, beyond the minimum 85% Medical Loss Ratio (MLR). The State will pay for 50% of additional medical costs between an 87% to 97% MLR. Above a 97% MLR the State will pay the following percentage of medical costs:

July 1, 2001 – December 31, 2001	90%
January 1, 2002 – June, 30, 2002	80%

Excluding the premium tax, an administrative fee of eleven percent (11%) of the CONTRACTOR's average capitation payment will be established with two (2) percentage points dependent on the achievement of benchmark levels of performance for specific performance indicators. Two (2) percentage points of the administrative fee will be allocated over the ten (10) performance indicators specified in Attachment XV. New or additional performance indicators may be added at the mutual agreement of TENNCARE and the CONTRACTOR. The CONTRACTOR must obtain the benchmark performance level for each indicator specified to be eligible for the portion of the two (2) percentage points allocated to that performance indicator. TENNCARE may modify the benchmarks on an annual basis to facilitate continuous improvement.

Option 2 shall only be available to a Managed Care Organization in which a provider or a provider entity has an indirect ownership interest, an ownership interest, or a control interest as defined at Title 42, Part 455, Subpart B of the Code of Federal Regulations, if the MCO agrees to allow TENNCARE to audit the CONTRACTOR's reimbursement methodologies and utilization management criteria, first, prior to the effective date of this Option, and again, after receipt of the settlement calculation for each settlement period. The purpose of the audit is to determine whether the CONTRACTOR pays more for similar services rendered by a related provider or subcontractor or applies differing utilization management controls than the CONTRACTOR pays or applies to providers and subcontractors that do not have an indirect ownership or control interest in the MCO, an MCO's affiliate or an MCO's management company for similar services. If

TENNCARE determines the CONTRACTOR pays related providers more than other providers or applies significantly different utilization management criteria during the initial audit, the CONTRACTOR shall not be permitted to elect Option 2. If TENNCARE determines the CONTRACTOR pays related providers more than other providers at a subsequent audit, the provisions specified in Section 3-10.e.3 shall apply.

Option 3 – The CONTRACTOR is responsible for the first $33 million in losses incurred during the period July 1, 2001 through June 30, 2002. Any Contractor selecting this option shall establish two separate accounts funded with $28 million dollars for operations expenses ("the Operations Account") and $5 million dollars for legal expenses and defense costs ("the Legal Contingency Account"). The CONTRACTOR shall allocate TennCare Contractor Costs defined as premium tax plus medical expenditures for covered services to the Operations Account. The CONTRACTOR shall allocate all non-medical liability costs to the Legal Contingency Account. Non-medical liability costs shall include, but not be limited to, legal defense costs, fees and damages associated with the Contractor's participation in the TennCare Program. In addition, said non-medical liability costs shall include costs for indemnification for such costs to the directors, officers, employees, agents and representatives of the CONTRACTOR and/or its parent company which are associated with the participation of those companies in the TennCare Program.

From July 1, 2001 through June 30, 2002, the CONTRACTOR shall deposit the capitation payments received from TennCare to the Operations Account to pay its Administrative Fee, in the amount specified below, and Contractor Costs related to its participation in the TennCare program. The Operations Account shall not be increased by the amount of investment income that the CONTRACTOR receives on the Operations Account nor by the Administrative Fee paid to the CONTRACTOR as specified below.

In the event that the CONTRACTOR's TennCare Contractor Costs allocated to the Operations Account exceed the $28 million in CONTRACTOR funds deposited in the Operations Account and the total of the difference between capitation payments received from TennCare and the fixed Admin Fee specified below, the State shall reimburse the CONTRACTOR for TennCare Contractor Costs exceeding the $28 million dollars at risk in the Operations Account, in accordance with the reimbursement methodology set forth in Section 4-26(2) of the CRA, provided, however that the Administrative Fee paid shall be equal to the amount described below for the applicable time period. The State is not responsible for and will not reimburse the CONTRACTOR for any non-medical liability costs. The CONTRACTOR is obligated and responsible for all of its non-medical liability costs, including any liability exceeding the $5 million deposited in the Legal Contingency Account for that purpose.

At the end of the term from July 1, 2001 through June 30, 2002:

(i) In the event that any balances remain in the Operations Account and the Legal Contingency Account, those accounts shall be reconciled and all funds remaining shall be the sole property of the CONTRACTOR;

(ii) In the event that any balance remains in the Legal Contingency Account and no balance remains in the Operations Account, the balance of the Legal Contingency Account will be applied to the amount of the funds the State has reimbursed the CONTRACTOR for TennCare Contractor Costs exceeding the $28 million dollars at risk in the Operations Account and said balance shall become the sole property of the State.

Admin Fee

Excluding the premium tax, an administrative fee will be established equivalent to 8.20% of the CONTRACTOR's average capitation payment for the month of January 2001 for the Contractor's intended service area. The product of this calculation stated on a per member per month basis will then be multiplied by 1.04 (to adjust for inflation) to calculate the administrative fee to be paid effective July 1, 2001. If the CONTRACTOR was not a TennCare MCO as of January 2001, the administrative fee will be equivalent to 8.20% of the average capitation payment for enrollees in the new MCO's authorized service area. The product of this calculation stated on a per member per month basis will then be multiplied by 1.04 (to adjust for inflation) to calculate the administrative fee to be paid effective July 1, 2001. The Administrative Fee shall serve as payment for all administrative costs, defined as all non-medical costs including costs of subcontractors engaged to perform an administrative function specifically related to securing or fulfilling the CONTRACTOR'S obligations to TENNCARE under the terms of the CRA and costs associated with liquidated damages.

Option 4 - The CONTRACTOR assumes all risk under this agreement.

The following selection is the Option that the CONTRACTOR chooses to execute under this Agreement for the period ending December 31, 2001:

___Option 1 ___Option 2 ___ Option 3 ___ Option 4

A risk banding manual is attached hereto and incorporated herein as Attachment XV.

3-10.e.3. Provider Reimbursement

The CONTRACTOR must agree to reasonable reimbursement standards to providers for covered medical services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

The CONTRACTOR shall not pay more for similar services rendered by any provider or sub CONTRACTOR that has an indirect ownership interest or an ownership or control interest in the MCO or an MCO's affiliates or an MCO'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 MCO, an MCO's affiliates or an MCO's management company for similar services. The standards and criteria for determining whether a provider or a provider subcontracting entity or a subcontractor has an indirect ownership interest, an ownership interest or a control interest are set out at Title 42, Part 455, Subpart B of the Code of Federal Regulations.

Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be reduced from total expenditures prior to the State sharing in any losses. Likewise, this excess payment will be excluded in the calculation of the medical loss ratio requirement. No later than fifteen (15) days following the end of each calendar quarter, the CONTRACTOR shall submit: (1) a list of all related providers and sub CONTRACTORs with which the CONTRACTOR has contracted during the preceding calendar quarter, and (2) a detailed explanation verifying that the payments made to such

related providers and sub CONTRACTORs are not in excess of the amounts allowed by this paragraph.

Determination of amounts due to or from the Contractor relative to risk sharing Options 1 or 2 will be measured in six month increments in calendar year 2001 and for the period January 1, 2002 through June 30, 2002. Determination of amounts due to or from the Contractor relative to risk sharing Option 3 will be measured for the period July 1, 2001 through June 30, 2002. The determination will be made using the financial reports for periods ending December 31 and June 30 of each year containing incurred but not reported claims estimates certified by an actuary as described in this section 3-10. A preliminary determination and settlement will be made ninety (90) days after receipt of actuarially certified reports. A final settlement will be made upon receipt of a report for the period ending either December 31 or June 30 in which an actuary has certified that an incurred but not reported amount that demonstrates that a claim run out of 95% for the calendar year has been achieved and the medical loss ratio requirement has been met.

3-10.f. Effect of Disenrollment on Capitation Payments

Payment of capitation payments shall cease effective the date of disenrollment 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. The CONTRACTOR shall not be required to refund any capitation amounts legitimately paid pursuant to this Agreement. 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 for medical care while the person was inappropriately enrolled in the CONTRACTOR's plan. In the event of enrollment obtained by fraud, misrepresentation or deception of individuals 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 any managed care organization 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.

3-10.g. Left Blank Intentionally

3-10.h. Stabilization Period Payment Terms and Conditions

Effective July 1, 2002 through June 30, 2005, all TennCare MCOs will operate under a non-risk agreement as set forth in this Section. This period shall be referred to as the “Stabilization Period”. During the Stabilization Period, MCOs will be paid an administrative fee to administer the TennCare MCO benefits in accordance with the Amended and Restated CRA, as amended. As set forth below, the administrative fee will consist of two components; a fixed administrative fee and a variable administrative fee.

In the event that the payment terms and conditions of the Stabilization Period including the fixed administrative fee specified in Section 3.10.h.1, the variable administrative fee specified in 3-10.h.3, and the amount of the Medical Fund Targets specified in Section 3.10.h.4 have not been established by July 1, 2002, the CONTRACTOR agrees to accept the capitation payment rates specified in Attachment X.A effective July 1, 2002. The CONTRACTOR agrees to reconcile said capitation payments (reduced by the amount of the fixed administrative fee to be specified in

Section 3.10.h.1 and applicable taxes which will be retained by the CONTRACTOR), to actual expenditures for medical services with dates of service from July 1, 2002 through the date of implementation of the payment terms specified in Section 3-10.h, within ninety (90) days of the end of this payment arrangement. Capitation payments are subject to TCA 56-32-224. The CONTRACTOR is responsible for making any payments required pursuant to TCA 56-32-224. The CONTRACTOR and TENNCARE shall mutually agree upon the form and format of the reconciliation. Said reconciliation may be subject to audit by the State, including the Comptroller of the Treasury or any of the State's Contractors or Agents. For the period beginning July 1, 2002 during which capitation payments are made: (1) To the extent that actual expenditures for medical expenses exceed total capitation payments (reduced by the fixed administrative fee and applicable taxes which will be retained by the CONTRACTOR), TENNCARE will pay the difference to the CONTRACTOR within thirty (30) days of receipt of the reconciliation; and (2) To the extent that actual expenditures for medical expenses were less than the total capitation payments (reduced by the fixed administrative fee and applicable taxes which will be retained by the CONTRACTOR), the CONTRACTOR agrees to pay the difference to TENNCARE within thirty (30) days of completion of the reconciliation.

3-10.h.1. Fixed Administrative Fee

The fixed administrative fee to be paid to the CONTRACTOR during the Stabilization Period shall be described in Attachment X.D of this Agreement.

3-10.h.2. Payment for Covered Services

Effective July 1, 2002, the CONTRACTOR shall not be at financial risk for the cost of covered services incurred by TennCare enrollees provided in accordance with the Amended and Restated Contractor Risk Agreement, as amended, unless the CONTRACTOR exercises its right to provide notice of termination in calendar year 2002 as specified in Section 4-2.f, as amended. This provision shall not relieve the CONTRACTOR from its responsibility to arrange for services in accordance with the terms of said Agreement, including requirements for timely claims processing specified in Section 2-9.m. Payment for covered services shall be made as follows:

3-10.h.2(a) Payment Requirements

The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002 for covered services as defined in Section 3-10.h.2(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider

3.10.h.2(b) Provider Payment Process

At such time as Section 3-10.h is modified to incorporate the fixed administrative rate, variable administrative rate and Medical Fund Targets, and beginning no later than August 1, 2002, the CONTRACTOR shall prepare checks for payment of providers for the provision of covered services incurred on or after the implementation date of this provision on a weekly basis, unless an alternative payment schedule is approved by TENNCARE. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 48 hours in advance of distribution of provider checks. The State shall release funds in the amount to be paid to providers to the

CONTRACTOR. Funds shall be released within 48 hours of receipt of notice. In turn, the CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State.

3-10.h.2(c) 1099 Preparation

The CONTRACTOR shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made.

3-10.h.2(d) Interest

Interest generated from the deposit of funds specified in Section 3-10.h.2(a) for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

3-10.h.2(e) Pharmacy Rebates

The amount of pharmacy rebates collected by the CONTRACTOR for TennCare enrollees shall be the property of the State. On a quarterly basis, the CONTRACTOR shall notify the State and provide supporting documentation of the value of said rebates. The first claims payment remittance request following the receipt of rebates will be reduced by the value of the rebates reported. This documentation shall be required to continue until such time as the run out of all claims processed by the CONTRACTOR or its subcontracted pharmacy benefits manager (PBM), as directed by TENNCARE.

3-10.h.2(f) Third Party Liability Resources

The CONTRACTOR shall be required to seek and collect third party subrogation amounts. The amount of provider payments specified in Section 3-10.h.2(a) shall be net of third party recoveries captured on the CONTRACTOR's claims processing system prior to notification of TENNCARE of the amount to be paid. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall also be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported. Further, the CONTRACTOR shall provide any information necessary in a format and media described by TENNCARE and shall cooperate as requested by TENNCARE, with TENNCARE and/or a Cost Recovery Vendor at such time that TENNCARE acquires said services.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 4-8 of this Agreement. It shall be the CONTRACTOR's responsibility to 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.

3-10.h.2(g) Reinsurance recoveries

In the event the CONTRACTOR maintains an aggregate or stop-loss reinsurance policy during the Stabilization Period, the CONTRACTOR shall reduce the total amount of the invoice to be paid by TennCare by the net amount of any reinsurance recoveries applicable to claims with dates of service after July 1, 2002. Furthermore, the CONTRACTOR agrees to cancel or retain a reinsurance policy during the Stabilization Period upon direction from TennCare.

3-10.h.2(h) HMO Payment Tax

Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-224 thirty days after the end of each calendar year quarter. 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.

3-10.h.2(i) Service Dates

Except where required by the CONTRACTOR's Agreement with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility in the CONTRACTOR's plan. 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 plan.

3-10.h.2(j) Covered Services

The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section 2-3 and payment of providers or enrollees in response to a directive from TennCare or an Administrative Law Judge. Otherwise, in the event the CONTRACTOR makes payment for a non-covered service, the State shall not be responsible for the payment of said service.

3-10.h.2(k) Cost-Sharing

Payments for covered services specified in Section 3-10.h.2(a) shall not include payment for enrollee cost-sharing amounts.

i. The claims payment amount shall be net of any amounts that the provider is entitled to collect pursuant to applicable coordination of benefits rules.

ii. When eligibility has been established by TENNCARE and the enrollee has incurred medical expenses that are covered benefits within the plan, the CONTRACTOR shall make reimbursement for the medical services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contract provider, the CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost share amounts. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost share amounts due from the enrollee as payment in full for the covered service.

iii. 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 X.C). If the CONTRACTOR had a TennCare Bureau approved alternative cost-share schedule in place during this retroactive period of eligibility, the CONTRACTOR may apply its alternative schedule.

3-10.h.3. Variable Administrative Fee Payment

The CONTRACTOR agrees Section 3-10.h.3 shall be applicable for the period July 1, 2002 through June 30, 2003 only. In addition to the fixed administrative fee specified in Section 3-10.h, the CONTRACTOR shall have an opportunity to earn a variable administrative fee payment. The variable administrative fee will not differ by eligibility category. The amount that is actually paid out to an individual MCO will vary based on the MCO's. The total amount of the variable administrative rate will be allocated over four performance objectives. The CONTRACTOR must meet the criteria for payment and obtain or exceed the level of performance for the performance measure specified in the table below to be eligible for the pay-out of the portion of the variable administrative fee allocated to that measure. Unless an alternative pay-out schedule is mutually agreed to by TENNCARE and the CONTRACTOR, TENNCARE will measure the CONTRACTOR's performance within ninety (90) calendar days of the end of the quarter and payouts shall be made within one hundred twenty (120) calendar days of the end of each quarter.

PERFORMANCE MEASURE	MEASUREMENT	BENCHMARK	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
A. Third Party Liability Recovery Rate	The amount of third party liability recoveries stated as a percentage of actual medical expenditures Numerator: Total amount of payments recovered from a third party payer, including worker's compensation, automobile insurance policies and other insurance policies for Medicaid and Disabled populations Denominator: Total amount paid for Medicaid and Disabled populations	Third party liability (TPL) recoveries related to claims paid during the quarter are at least 3.2% of claims paid	On a quarterly basis, if total medical expenses per member per month are less than the sum of each MFT*1.05: AN AMOUNT TO BE DETERMINED BY TENNCARE, per Medicaid and Disabled member per month	If TPL Recovery Rate equal to or greater than 0.8% and less than 1.6%: TO BE DETERMINED BY TENNCARE *Member Months for Medicaid and Disabled Populations for the Preceding Quarter*.25 If TPL Recovery Rate equal to or greater than 1.6% and less than 2.4%: TO BE DETERMINED BY TENNCARE *Member Months for Medicaid and Disabled Populations for the for Preceding Quarter*.50 If TPL Recovery Rate equal to or greater than 2.4% and less than 3.2%" TO BE DETERMINED BY TENNCARE *Member Months for Medicaid and Disabled Populations for the Preceding Quarter*.75 If TPL Recovery Rate equal to or greater than 3.2%: AN AMOUNT TO BE DETERMINED BY TENNCARE * Member Months for Medicaid and Disabled Populations for the Preceding Quarter*1.0	Reported on invoice for provider payments and encounter data

PERFORMANCE MEASURE	MEASUREMENT	BENCHMARK	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
B. EPSDT Screening Rate	EPSDT screening rate calculated in accordance with the HCFA-416 Numerator: Total number of screenings (Line 6) Denominator: Expected number of screenings (Line 5)	80% of children under the age of 21 receive timely and complete EPSDT screenings	On a quarterly basis, AN AMOUNT TO BE DETERMINED BY TENNCARE* per member per month	If EPSDT Screening Rate equal to or greater than 60% and less than 65%, or, a ten percentage point improvement over CY2001: AN AMOUNT TO BE DETERMINED BY TENNCARE * Member Months for Preceding Quarter*.20 If EPSDT Screening Rate equal to or greater than 65% and less than 70%, Pay Out: AN AMOUNT TO BE DETERMINED BY TENNCARE *Member Months for Preceding Quarter*.40 If EPSDT Screening Rate equal to or greater than 70% and less than 75%, Pay Out: AN AMOUNT TO BE DETERMINED BY TENNCARE *Member Months for Preceding Quarter*.60 If EPSDT Screening Rate equal to or greater than 75% and less than 80%, Pay Out: AN AMOUNT TO BE DETERMINED BY TENNCARE *Member Months for Preceding Quarter*.80 If EPSDT Screening Rate equal to or greater than 80%: AN AMOUNT TO BE DETERMINED BY TENNCARE *Member Months for Preceding Quarter*1.0	EPSDT Screening Rate: MCO encounter data

PERFORMANCE MEASURE	MEASUREMENT	BENCHMARK	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
C. Single-Source Drug Utilization Rate	The percentage of total prescriptions filled for single-source prescription drugs. Numerator: The total number of prescriptions for single-source drugs Denominator: The total number of prescriptions	25% of prescriptions are filled with single -source prescription drugs	On a quarterly basis, if total medical expenses per member per month are less than the sum of each MFT*1.05: AN AMOUNT TO BE DETERMINED BY TENNCARE per member per month	If single-source utilization rate less than 35% but greater than or equal to 30%: AN AMOUNT TO BE DETERMINED BY TENNCARE *Member Months for Preceding Quarter*.33 If single-source utilization rate less than 30% but greater than or equal to 25%: AN AMOUNT TO BE DETERMINED BY TENNCARE * Member Months for Preceding Quarter*.66 If single-source utilization rate 25% or less: AN AMOUNT TO BE DETERMINED BY TENNCARE * Member Months for Preceding Quarter*1.0	MCO encounter data

PERFORMANCE MEASURE	MEASUREMENT	BENCHMARK	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
D. Pharmacy Management	The percentage of physicians who prescribe non-formulary prescription drugs who are contacted by the MCO within five (5) calendar days Numerator: The total number of physicians who prescribed non-formulary drugs who are contacted within five (5) calendar days of date of prescription fill Denominator: The total number of physicians who prescribed non-formulary drugs	95% of physicians (See Note) who prescribe a non-formulary prescription drug for more than a 14 day supply are contacted by the MCO within five (5) calendar days of the date the prescription is filled for the purpose of formulary education and changing the prescription to a formulary drug NOTE: Contact must be made by fax or telephone with the prescribing physician or a provider practicing with the prescribing physician	On a quarterly basis, if total medical expenses per member per month are less than the sum of each MFT*1.05: AN AMOUNT TO BE DETERMINED BY TENNCARE per member per month	If 95% or more of physicians who prescribe non-formulary prescription drugs are contacted within five (5) calendar days of the date of prescription fill, AN AMOUNT TO BE DETERMINED BY TENNCARE * Member Months	Log to be maintained by the MCO, indicating Name of Physician, Prescription drug prescribed, Date of Prescription fill, Date of Contact, Result of Contact

3-10.h.3(a) Variable Administrative Fee Payment for Fiscal Year 2005

The CONTRACTOR agrees Section 3-10.h.3(a) shall be applicable for the period October 1, 2004 through September 30, 2005 only. In addition to the fixed administrative fee specified in Section 3-10.h, the CONTRACTOR shall have an opportunity to earn a variable administrative fee payment subject to the availability of funds. The variable administrative fee will not differ by eligibility category. The amount that is actually paid out to an individual MCO will vary based on the MCO's level of performance. The CONTRACTOR must meet the criteria for payment and obtain or exceed the level of performance for the performance measure specified in the table below to be eligible for the pay-out of the portion of the variable administrative fee allocated to that measure. Unless an alternative pay-out schedule is mutually agreed to by TENNCARE and the CONTRACTOR, TENNCARE will measure the CONTRACTOR's performance within one hundred eighty (180) calendar days of the end of the federal fiscal year and payouts shall be made, subject to the availability of funds, within thirty (30) calendar days thereafter. The CONTRACTOR shall be responsible for maintaining data to validate increased EPSDT Complete Medical Screening Rates. Data may be reviewed and audited by TENNCARE.

PERFORMANCE	MEASUREMENT	BENCHMARK	PAY-OUT	DATA

MEASURE			FORMULA	SOURCE
EPSDT Complete Medical Screening Rate	EPSDT complete medical screening rate shall be calculated by multiplying the EPSDT screening ratio, calculated in accordance with specifications for the HCFA-416 report, by the percentage of the required seven (7) components that are completed as determined through the MCO's documentation	80% of children under the age of 21 receive timely and complete EPSDT Medical screenings	If EPSDT Complete Medical Screening Rate equal to or greater than 65% and less than 70%, Pay Out: .40 per child per month OR If EPSDT Complete Medical Screening Rate equal to or greater than 70% and less than 75%, Pay Out: .60 per child per month OR If EPSDT Complete Medical Screening Rate equal to or greater than 75% and less than 80%, Pay Out: .80 per child per month OR If EPSDT Complete Medical Screening Rate equal to or greater than 80%: 1.0 per child per month	EPSDT Screening Rate: MCO encounter data 7 Components of a Screen: MCO data which may be audited by TENNCARE

3-10.h.4. Medical Fund Target

The CONTRACTOR agrees that the incentive payment as described in this Section 3-10.h.4 shall be applicable for the period July 1, 2002 through June 30, 2003. Subject to the availability of State funds and/or appropriations, in order to provide an incentive to manage the medical costs and utilization of TennCare enrollees during the Stabilization Period, the CONTRACTOR may be eligible for an incentive payment, separate from the variable administrative rate described in Section 3-10.h.3, to be determined based on the amount of actual expenditures for covered services incurred during the Stabilization Period relative to a Medical Fund Targets established by TENNCARE in aggregate. To administer this incentive, TENNCARE shall establish separate medical fund targets that shall be stated on a per member per month basis by major eligibility grouping. The CONTRACTOR shall be eligible for an incentive payment equivalent to twenty-five percent (25%) of the first five percent (5%) difference between the aggregate amount of the Medical Fund Targets and total payments for covered services, excluding payments for non-covered services made in response to a directive from TENNCARE or an Administrative Law Judge. It shall be the responsibility of the CONTRACTOR to provide sufficient documentation to identify payments made for non-covered services made in response to a directive from TENNCARE or an Administrative Law Judge to be excluded from the amount of total payments for covered services.

The CONTRACTOR shall submit a Medical Fund Target Monitoring Report monthly with cumulative year to date calculation using the forms in Attachment XII, Exhibit J in accordance with Section 2-10.j of this Agreement.

3-10.h.5. Disallowances

The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with the requirements of this Agreement, including but not limited to, requirements to pay providers in accordance with reimbursement rates and medical management polices and procedures in effect as of April 16, 2002, as specified in Section 2-9, as amended, unless otherwise approved or directed by TENNCARE. In the event TENNCARE determines a cost was not incurred in accordance with this Agreement, TENNCARE reserves the right to disallow said cost and reduce the amount of future fixed administrative fee payments by the amount of the disallowance. The CONTRACTOR shall provide TENNCARE and/or an auditor for the TennCare Program access to all information necessary to perform the examination. In the event that a future fixed administrative fee payment is not scheduled at the time a disallowance is identified, or the amount of the disallowance exceeds the amount of the fixed administrative rate payment, the CONTRACTOR shall reimburse the State for the amount of the disallowance within thirty (30) calendar days of receipt of written notice.

3-10.h.6. Provider Reimbursement

The CONTRACTOR must agree to reasonable reimbursement standards to providers for covered medical services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

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 MCO or an MCO's affiliates or an MCO'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 MCO, an MCO's affiliates or an MCO's management company for similar services. The standards and criteria for determining whether a provider or a provider subcontracting entity or a subcontractor has an indirect ownership interest, an ownership interest or a control interest are set out at Title 42, Part 455, Subpart B of the Code of Federal Regulations.

Any payments made by the CONTRACTOR that exceed the limitations set forth in this Section shall be reduced from total expenditures prior to the State sharing costs for covered services. No later than fifteen (15) days following the end of each calendar quarter, the CONTRACTOR shall submit: (1) a list of all related providers and subcontractors with which the CONTRACTOR has contracted during the preceding calendar quarter, and (2) a detailed explanation verifying that the payments made to such related providers and subcontractors are not in excess of the amounts allowed by this paragraph.

3-10.h.7. Effect of Disenrollment on the Fixed Administrative Fee Payments

Payment of the fixed administrative fee shall cease on the effective date of disenrollment and the CONTRACTOR shall have no further responsibility for the care of the enrollee. TENNCARE shall adjust administrative fees to reflect the effective date of disenrollment.

Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively. The CONTRACTOR shall not be required to refund any administrative fee payments legitimately paid pursuant to this Agreement. In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TennCare all fixed administrative fee payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR shall make a good faith effort to pursue full restitution for all payments made for medical care while the person was inappropriately enrolled in the CONTRACTOR's plan. In the event of enrollment obtained by fraud, misrepresentation or deception of individuals by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover fixed administrative fee payments and payments for covered services incurred by the enrollee plus interest, as allowed by TCA 47-14-103, and any other monies paid to any managed care organization for the enrollment of that individual. The refund of payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

3-10.i. Shared Risk Terms and Conditions

Effective July 1, 2005, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits in accordance with the Amended and Restated CRA, as amended.

To balance the Shared Risk framework, TennCare has established two components to the Model: Risk based (downside potential) and Bonus based (upside potential). These components shall encompass the Medical Services Budget Targets (MSBT), Administrative Fee paid to the MCO, and five (5) TennCare priority initiatives: Pharmacy, NCQA, and EPSDT, Emergency Room Visits per 1000 and Inpatient Admissions per 1000. The Medical Services Budget Targets (medical costs) will be the key component for the shared risk model. For the period July 1, 2005 through June 30, 2006, where appropriate, benchmarks will be based on each MCOs individual experience as described below. Some of the benchmarks are derived from the CONTRACTOR's self reported information; however, to the extent that TENNCARE produces the benchmark, TENNCARE shall provide the CONTRACTOR with the individual benchmarks for those initiatives by June 15, 2005. Effective July 1, 2006, all benchmarks, with the exception of the EPSDT screening rate, will be based on performance measures established by TENNCARE using claims data submitted by the CONTRACTOR and in addition to the benchmarks described above shall include Inpatient Days per 1000.

As relates to the Medical Services Budget Target, Non-Emergency ER Visits per 1000, EPSDT Compliance, Inpatient Admissions per 1000, Inpatient Days per 1000, and Pharmacy Generic Usage, the parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology that shall be agreed upon by both parties.

The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population. As an integral part of evaluating the CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for

acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Agreement as they are performed and interpreted as of July 1, 2006. As such, services provided as a result of compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Agreement as of July 1, 2006 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

3-10.i.1. Administrative Fee

The CONTRACTOR shall be paid an administrative fee based on the number of enrollees assigned to the plan as described in Attachment X.

3-10.i.2 Medical Services Budget Target

(a) The CONTRACTOR shall submit a Medical Services Monitoring Report monthly with cumulative year to date calculation using the instructions in Attachment XII, Exhibit J in accordance with Section 2-10.j of this Agreement. From this report, TennCare will compute a quarterly Medical Services Budget Target. This will be established by computing the percent change for each quarter two years historically. A percent change will be computed for each quarter compared to the prior year quarter. This trend will be applied to the per member costs for previous year quarter to establish the Medical Services Budget Target for future quarters.

The MSBT will be evaluated in terms of the prior year quarter for the same timeframe (i.e. 3rd Qtr 2005 will be compared to 3rd Qtr 2004). The data from the Medical Services Budget Target quarterly update will be used to establish the quarterly PMPMs.

(b) Effective July 1, 2006, the MSBT Benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

(c) Effective July 1, 2007, the MSBT benchmark will be established on a regional basis by rate cell using historical claims data. Trends will be applied for utilization and adjustments for moderately management of care based on recommendations of actuaries contracted by the State.

3-10.i.3. Risk Component

The Shared Risk Model will require that a percent of the overall budget that is directly related to patient care and overall medical costs be placed at risk. The Model will set ten percent (10%) of the administrative fee (or budget) at risk; the ten percent (10%) will either be earned or lost based on Plan performance.

The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
Medical Services Budget Target	2.0%
Usage of Generic Drugs	2.0%
Completion of Major Milestone for NCQA	1.0%
EPSDT Compliance	2.0%
Non-Emergency ER Visits per 1000	1.0%
Inpatient Admissions per 1000	1.0%
Inpatient Days per 1000	1.0%

3-10.i.3(a) Medical Services Budget Target Initiative

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 2% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(b) Pharmacy Generic Use:

The Bureau will establish current generic trends for each MCO based on utilization data reported by the Pharmacy Benefits Manager (PBM).

This initiative targets the pharmacy generic use rates for the MCOs. Each MCO will have a target established for their enrollee population based on the MCOs individual experience. Administrative fees will be adjusted based on deviations from the MCO generic use benchmark as listed below.

Percent of Generic Usage Target	Administrative Fee Adjustment
≥ 95%	All admin assoc with Generic Drug Usage at risk portion and potential bonus
< 95% and ≥ 90%	-25% of admin assoc Generic Drug Usage risk portion
< 90% and ≥ 85%	-50% of admin assoc Generic Drug Usage risk portion
< 85% and ≥ 80%	-75% of admin assoc Generic Drug Usage risk portion
< 80%	-100% of admin assoc Generic Drug Usage risk portion

Evaluation Period: Annual
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: October 1, 2005 (after the TennCare Reform change in enrollment)

3-10.i.3(c) Completion of Major Milestones for NCQA:

A major initiative for TennCare is the accreditation of all MCOs by NCQA. The Bureau has established an 18 month timeframe for all MCOs to be accredited. There are critical milestones that must be adhered to by the MCOs. Listed below are the major milestones with the associated due date as referenced in the Amended and Restated Contractor Risk Agreement.

For dates of service July 1, 2005 through June 30, 2006, the NCQA benchmarks are as follows:

1. Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO. **Due Date: September 15, 2005.**

2. NCQA Accreditation Survey Application Submitted and Pre-Survey Fee Paid. **Due Date: November 15, 2005.**

3. Copy of Signed Contract with NCQA Approved Vendor to Perform 2006 CAHPS Survey to TennCare Chief Medical Officer. **Due Date: November 15, 2005.**

4. Copy of Signed Contract with NCQA Approved Vendor to Perform 2006 HEDIS Audit to TennCare Chief Medical Officer. **Due Date: November 15, 2005.**

5. Copy of Signed Contract with NCQA Survey Contract to TennCare Chief Medical Officer. **Due Date: December 15, 2005.**

A **0.4%** reduction in admin fee associated with NCQA will be assessed for each milestone not met.

Evaluation Period: By Specified Due Date
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

Effective July 1, 2006 the NCQA benchmarks are as follows:

1. Submit ISS to NCQA. **Due Date: September 18, 2006**.

2. NCQA Survey Completed and copy of NCQA Final Report to TennCare
Due Date: December 31, 2006

A **0.5%** reduction in admin fee associated with NCQA will be assessed for each milestone not met.

Evaluation Period: By Specified Due Date
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2006

3-10.i.3(d) Increase EPSDT Compliance

The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Amended and restated Contractor Risk Agreement. Section 3-10.h.3(a) currently provides opportunity for the CONTRACTOR to receive a bonus for increasing EPSDT screening rates for the time period October 1, 2004 through September 30, 2005 only. The TennCare Program goal for EPSDT compliance is 80% and the CONTRACTOR shall make every effort to attain said goal. Effective July 1, 2006 a percentage of the administrative fee shall be placed at risk based on the CONTRACTOR's compliance with an EPSDT screening rate of 80%.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	**Administrative Fee Adjustment**
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(e) Non-Emergency ER Visits per 1000:

TennCare will establish benchmarks for Non Emergency ER visits. Each MCO Non Emergency ER Visits/1000 benchmark will be derived from the Plan Cost and Utilization reports. TENNCARE shall provide the CONTRACTOR with a document which shall define Non-Emergency ER Visits for the purposes of reporting and documenting the achievement of this benchmark. Effective July 1, 2006, the ER Visits/1000 benchmark

shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

Percentage of ER Visists/1000 (NE) Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with ER Visits per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc ER Visits per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc ER Visits per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc ER Visits per 1000 risk portion
> 120% and greater	-100% of admin assoc ER Visits per 1000 risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(f) Inpatient Admissions per 1000:

TennCare will establish benchmarks for Inpatient Admits/1000. Effective July 1, 2005 through June 30, 2006, each MCO Inpatient Admits/1000 benchmark will be derived from the Plan Cost and utilization reports. Effective July 1, 2006, the Inpatient Admits per 1000 benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

Percentage of Inpatient Admissions/1000 Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with Inpatient Admits per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc Inpatient Admits per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc Inpatient Admits per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc Inpatient Admits per 1000 risk portion
> 120% and greater	-100% of admin assoc Inpatient Admits per 1000 risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(g) Inpatient Days Per 1000

TennCare will establish benchmarks for Inpatient Days per 1000 based on the CONTRACTOR's claims data and shall provide the benchmark to the CONTRACTOR prior to July 1, 2006.

Percentage of Inpatient Days per 1000 Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with Inpatient Days per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc Inpatient Days per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc Inpatient Days per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc Inpatient Days per 1000 risk portion
> 120% and greater	-100% of admin assoc Inpatient Days per 1000 risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2006

3-10.i.4. Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative. The bonus pool will represent fifteen percent (15%) of the administrative fee for the CONTRACTOR as described in Attachment X. The following Initiatives will be included in the Bonus Pool: Medical Services Budget Target, Generic Usage, EPSDT Compliance, ER Visits/1000 (NE), and Inpatient Admits/1000. Effective July 1, 2006, Inpatient Days per 1000 shall be one of the initiatives included in the Bonus Pool. Effective July 1, 2007, the bonus pool will represent twenty percent (20%) of the administrative fee for the CONTRACTOR as described in Attachment X. The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus
Medical Services Budget Target	10.0%
Usage of Generic Drugs	2.0%
EPSDT Compliance	2.0%
ER Visits/1000 (NE)	2.0%
Inpatient Admits/1000	2.0%
Inpatient Days/1000	2.0%

The distribution of bonuses are tied to the assumptions listed in the table below and are computed after they are weighted by the contribution of the Initiatives to the Bonus Pool. The effective dates for each bonus pool initiative are as follows: MSBT – July 1, 2005; Generic Drugs Rate – October 1, 2005; EPSDT Compliance – July 1, 2005; ER.Visits/1000 (NE) – July 1, 2005; Inpatient Admits/1000 – July 1, 2005; and Inpatient Days/1000 – July 1, 2006.

Additional Bonus Points

Performance – Percent Exceeding Target	**Usage of Generic Drugs Target**	**EPSDT Compliance Target**
> 100% and ≤ 105%	25%	25%
> 105% and ≤ 110%	50%	50%
> 110% and ≤ 120%	75%	75%
> 120% and over	100%	100%

Performance – Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

Performance – Percent Improving Target	ER Visits/1000 (NE) Target	Inpatient Admits/1000 Target	Inpatient Days/1000 Target
< 100% and ≥ 95%	25%	25%	25%
< 95% and ≥ 90%	50%	50%	50%
< 90% and ≥ 85%	75%	75%	75%
< 85%	100%	100%	100%

3-10.i.5 Risk and Bonus Payout Reconciliation

The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Reconciliation of the administrative fees shall occur two (2) times a year on January 1 and July 1. Payouts for determinations that have been made for the 1st and 2nd Quarters shall be made by January 1 of the following year and payouts for determinations that have been made for the 3rd and 4th Quarters shall be made by July 1 of the following year.

In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.

If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

3-10.i.6 Payment for Covered Services

Effective July 1, 2005, the CONTRACTOR shall not be at financial risk for the cost of covered services incurred by TennCare enrollees provided in accordance with the Amended and Restated Contractor Risk Agreement, as amended. This provision shall not relieve the CONTRACTOR from its responsibility to arrange for services in accordance with the terms of said Agreement, including requirements for timely claims processing specified in Section 2-9.m. Payment for covered services shall be made as follows:

3-10.i.6(a) Payment Requirements

The CONTRACTOR shall continue to reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002 for covered services as defined in Section 3-10.i.6(i), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider. The CONTRACTOR shall assure 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 2-18 of this Agreement.

3.10.i.6(b) Provider Payment Process

The CONTRACTOR shall prepare checks for payment of providers for the provision of covered services incurred on or after the implementation date of this provision on a weekly basis, unless an alternative payment schedule is approved by TENNCARE. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice. In turn, the CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State and provide TENNCARE with a check register or similar document that is generated from the managed care claims processing system supporting the release of these payments by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers. The CONTRACTOR should provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

The CONTRACTOR shall pursue and report on providers which maintain an accounts-payable balance or maintain outstanding checks in accordance with Section 2-10.e.3 of this Agreement.

3-10.i.6(c) 1099 Preparation

The CONTRACTOR shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made.

3-10.i.6(d) Interest

Interest generated from the deposit of funds specified in Section 3-10.i.6(a) for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

3-10.i.6(e) Third Party Liability (TPL) Resources

The CONTRACTOR shall be required to seek and collect third party subrogation amounts regardless of the amount available or believed to be available as required by federal guidelines. The amount of provider payments specified in Section 3-10.g.6(a) shall be net of third party recoveries captured on the CONTRACTOR's claims processing system prior to notification of TENNCARE of the amount to be paid. The CONTRACTOR shall post all third party payments to claim level detail by enrollee. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall also be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request/encounter submission (when applicable) subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported. Further, the CONTRACTOR shall provide any information necessary in a format and media described by TENNCARE and shall cooperate as requested by TENNCARE, with TENNCARE and/or a Cost Recovery Vendor at such time that TENNCARE acquires said services.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 4-8 of this Agreement. It shall be the CONTRACTOR's responsibility to 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.

3-10.i.6(f) Reinsurance recoveries

In the event the CONTRACTOR maintains an aggregate or stop-loss reinsurance policy, the CONTRACTOR shall reduce the total amount of the invoice to be paid by TennCare by the net amount of any reinsurance recoveries applicable to claims with dates of service after July 1, 2002. Furthermore, the CONTRACTOR agrees to cancel or retain a reinsurance policy during the Stabilization Period upon direction from TennCare.

For MCOs who have reinsurance policies in effect, the CONTRACTOR shall reconcile their claims payments against the terms of their reinsurance policy for appropriate action and shall provide TENNCARE with quarterly reports that reflect the CONTRACTOR's findings and actions.

3-10.i.6(g) HMO Payment Tax

Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-224 thirty days after the end of each calendar year quarter. 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.

3-10.i.6(h) Service Dates

Except where required by the CONTRACTOR's Agreement with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility or after the termination date in the CONTRACTOR's plan. 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 plan.

3-10.i.6(i) Covered Services

The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section 2-3 and payment of providers or enrollees in response to a directive from TennCare or an Administrative Law Judge. Otherwise, in the event the CONTRACTOR makes payment for a non-covered service, the State shall not be responsible for the payment of said service.

3-10.i.6(j) Cost-Sharing

Payments for covered services specified in Section 3-10.i.6(a) shall not include payment for enrollee cost-sharing amounts.

i. The claims payment amount shall be net of any amounts that the provider is entitled to collect pursuant to applicable coordination of benefits rules.

ii. When eligibility has been established by TENNCARE and the enrollee has incurred medical expenses that are covered benefits within the plan, the CONTRACTOR shall make reimbursement for the medical services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contract provider, the CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost share amounts. The CONTRACTOR shall require, as a condition of payment, that the service 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 payor) plus any applicable amount of TennCare cost share amounts due from the enrollee as payment in full for the covered service.

iii. 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 X.C). If the CONTRACTOR had a TennCare Bureau approved alternative cost-share schedule in place during this retroactive period of eligibility, the CONTRACTOR may apply its alternative schedule.

3-10.i.7. Disallowances

The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with the requirements of this Agreement, including but not limited to, requirements to pay providers in accordance with reimbursement rates and medical management polices and procedures in effect as of April 16, 2002, as specified in Section 2-9, as amended, unless otherwise approved or directed by TENNCARE. In the event TENNCARE determines a cost was not incurred in accordance with this Agreement, TENNCARE reserves the right to disallow said cost and reduce the amount of future fixed administrative fee payments by the amount of the disallowance. The CONTRACTOR shall provide TENNCARE and/or an auditor for the TennCare Program access to all information necessary to perform the examination. In the event that a future fixed administrative fee payment is not scheduled at the time a disallowance is identified, or the amount of the disallowance exceeds the amount of the fixed administrative rate payment, the CONTRACTOR shall reimburse the State for the amount of the disallowance within thirty (30) calendar days of receipt of written notice.

3-10.i.8. Provider Reimbursement

The CONTRACTOR must agree to reasonable reimbursement standards to providers for covered medical services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State. At such time that TENNCARE develops a provider fee schedule for use by all of the TennCare MCOs, the CONTRACTOR shall agree to implement, within a reasonable timeframe, said fee schedule.

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 MCO or an MCO's affiliates or an MCO'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 MCO, an MCO's affiliates or an MCO's management company for similar services. The standards and criteria for determining whether a provider or a provider subcontracting entity or a subcontractor has an indirect ownership interest, an ownership interest or a control interest are set out at Title 42, Part 455, Subpart B of the Code of Federal Regulations.

Any payments made by the CONTRACTOR that exceed the limitations set forth in this Section shall be reduced from total expenditures prior to the State sharing costs for covered services. No later than fifteen (15) days following the end of each calendar quarter, the CONTRACTOR shall submit: (1) a list of all related providers and subcontractors with which the CONTRACTOR has contracted during the preceding calendar quarter, and (2) a detailed explanation verifying that the payments made to such related providers and subcontractors are not in excess of the amounts allowed by this paragraph.

3-10.i.9. Effect of Disenrollment on the Fixed Administrative Fee Payments

Payment of the fixed administrative fee shall cease on the effective date of disenrollment and the CONTRACTOR shall have no further responsibility for the care of the enrollee. TENNCARE shall adjust administrative fees to reflect the effective date of disenrollment. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively. The CONTRACTOR shall not be required to refund any administrative fee payments legitimately paid pursuant to this Agreement. In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TennCare all fixed administrative fee payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR shall make a good faith effort to pursue full restitution for all payments made for medical care while the person was inappropriately enrolled in the CONTRACTOR's plan. In the event of enrollment obtained by fraud, misrepresentation or deception of individuals by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover fixed administrative fee payments and payments for covered services incurred by the enrollee plus interest, as allowed by TCA 47-14-103, and any other monies paid to any managed care organization for the enrollment of that individual. The refund of payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

3-10.i.10. Additional Payment for Specified Achievement Level of Initial NCQA Accreditation

In addition to the fixed administrative fee specified in Section 3-10.i, the CONTRACTOR may obtain additional payments for the successful achievement of initial NCQA Accreditation.

PERFORMANCE MEASURE	MEASUREMENT	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
NCQA Accreditation Status	NCQA Accreditation Status Achieved: 1. Excellent 2. Commendable 3. Accredited 4. Provisional 5. Denied	Initial Accreditation Fees that qualify as reimbursable: Application and Pre-Survey Fee, Base Survey Fee, and the additional Per Member Fee **NOTE: Proof of payment to NCQA will be required for reimbursement**	Reimbursed at the following rates: 1. Excellent – 100% 2. Commendable – 80% 3. Accredited – 60% 4. Provisional – 40% 5. Denied – 0 **NOTE: Fees associated with resurveys within three years of the initial accreditation status determination will not be reimbursed.**	NCQA Final Accreditation Status Report

Payout for reimbursable expenses shall occur within thirty (30) days of receipt by TENNCARE of proof of the CONTRACTOR’s NCQA paid invoice.

3-10.i.11. Pay-for-Performance Quality Incentive

On July 1, 2007 the CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of July 1, 2006 to December 31, 2006, if their HEDIS 2007 HbA1C testing rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS HbA1C testing rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the following table where the CONTRACTOR's 2006 HEDIS HbA1C testing rate represents the baseline.

NCQA Minimum Effect Size Change Requirements:

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

In addition, on July 1, 2007, the CONTRACTOR will be eligible for another $0.03 pmpm applied to member months from the period of July 1, 2006 – December 31, 2006. This additional payment will be made if the CONTRACTOR's 2007 HEDIS Prenatal Care rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS Prenatal Care rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the table above where the MCO's 2006 HEDIS Prenatal Care rate represents the baseline.

On December 31, 2007, the CONTRACTOR will be eligible for an additional $0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for asthma has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with asthma as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with asthma in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

In addition, on December 31, 2007, the CONTRACTOR will be eligible for an another $0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with congestive heart failure as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with congestive heart failure in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

On July 1, 2008, the CONTRACTOR will be eligible for a $0.03 pmpm payment, applied to member months from the period January 1, 2007 to December 31, 2007, for each of the following 2008 HEDIS or CAHPS measures for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology, where the applicable 2007 HEDIS or CAHPS score serves as the baseline.

- HbA1C Testing
- Controlling High Blood Pressure
- Timeliness of Prenatal Care
- Postpartum Care
- Adolescent Immunizations (combo2)
- Childhood Immunizations (combo 2)
- Cervical Cancer Screening

3-10.i.12. The administrative fee payments specified in Section 3-10.i, including but not limited to Section 3-10.i.6(g) and Attachment X of this Agreement, as amended, shall represent payment in full. 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.

3-11. Services Provided by TennCare

TennCare shall be responsible for the payment of the following services:

3-11. a. For qualified individuals in accordance with TennCare policies and/or TennCare rules and regulations, costs of long term care institutional services in a nursing home, or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver-covered services provided through the Home and Community Based Services (HCBS) waivers, with the exception of the first one hundred (100) days of convalescent care, as described in Section 2-3.a.1 and 2-3.f of this Agreement;

3-11. b. Medicare buy-in premiums, Medicare deductibles and Medicare coinsurance amounts for enrollees who are dually eligible for Medicare and Medicaid;

3-11. c. Pharmacy Benefits for Medicare and TennCare dual eligibles after TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category;

3-11. d. Effective October 1, 2002, dental services as described in Sections 2-3.a.1 and 2-3.c.3 of this Agreement; and

3-11. e. Effective July 1, 2003, all TennCare pharmacy benefits as described in Section 2-3.a.1 of this Agreement.

3-12. 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.

3-13 Pharmacy Encounter Data

The TENNCARE Bureau will provide to each MCO, monthly pharmacy encounter data for all the MCO's enrollees whose claims are the financial responsibility of TENNCARE, including TennCare/Medicare enrollees assigned to the MCO to the extent allowed by state and federal law. This data exchange will allow the MCO's to integrate this information into their case management and medical management systems to improve the quality of care for TennCare enrollees.

SECTION 4 - TERMS AND CONDITIONS

4-1. 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), and court orders, including Constitutional provisions regarding due process and equal protection of the laws and including but not limited to:

4-1. a. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4-1. b. Title 45 CFR, Part 74, General Grants Administration Requirements.

4-1. c. 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.

4-1. d. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.).

4-1. e. Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 C.F.R. Part 80.

4-1. f. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment.

4-1. g. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 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 C.F.R. Part 84.

4-1. h. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

4-1. i. The Omnibus Budget Reconciliation Act of 1981, P.E.. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

4-1. j. Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq., and regulations issued pursuant thereto, 28 C.F.R. Parts 35, 36.

4-1. k. Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program.

4-1. l. Tennessee Consumer Protection Act, T.C.A. Section 47-18-101 et seq.

4-1. m. The HCFA waiver and all Special Terms and Conditions which relate to the waiver.

4-1. n. Executive Orders, including Executive Order 1 effective January 26, 1995.

4-1. o. The Clinical Laboratory Improvement Act (CLIA) of 1988.

4-1. p. Requests for approval of material modification as provided at TCA 56-32-201 etc .seq.

4-1. q. Investigatory Powers of the Tennessee Department of Commerce and Insurance pursuant to Tennessee Code Annotated Section 56-32-232.

4-1. r. 42 USC Section 1396 et seq. (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4-1. s. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.

4-1. t. Title IX of the Education Amendments of 1972 regarding education programs and activities.

4-1. u. Title 42 CFR 422.208 and 210, Physician Incentive Plans.

4-1. v. EEO Provisions.

4-1. w. Copeland Anti-Kickback Act .

4-1. x. Davis-Bacon Act.

4-1. y. Contract Work Hours and Safety Standards.

4-1. z. Rights to Inventions Made Under a Contract or Agreement.

4-1. aa. Byrd Anti-Lobbying Amendment.

4-1. bb. Contracts and subcontracts and subgrants of amounts in excess of $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.)

4-1. cc. 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 (Pub. L. 94-165.)

4-1. dd. TennCare Reform Legislation signed May 11, 2004 and any subsequent implementation schedule as specified by TENNCARE.

4-1.ee. Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

4-2. 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 parts 4-2.a., 4-2.b., 4-2.c. or 4-2.e. TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the plan.

4-2.a. 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.

4-2.b. Termination by TENNCARE for Cause

4-2.b. 1. The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

4-2.b.1. (a) The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

4-2.b.1. (b) The CONTRACTOR only renders partial performance of any term or provision of the Agreement; or

4-2.b.1. (c) The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

For purposes of Section 4-2.b, items (a) through (c) shall hereinafter be referred to as "Breach."

4-2.b. 2. 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:

4-2.b.2. (a) Recovery of actual damages, including incidental and consequential damages, and any other remedy available at law or equity;

4-2.b.2. (b) Requirement that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;

4-2.b.2. (c) Recover any and all liquidated damages provided in this Agreement;

4-2.b.2. (d) Declare a partial default; and

4-2.b.2. (e) Declare a default and terminate this Agreement.

In the event of a conflict between any other Agreement provisions and this provision, this provision shall control.

4-2.b. 3. 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.

4-2.b. 4. 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.

4-2.b. 5. Partial Default

4-2.b.5. (a) If the CONTRACTOR fails to cure the Breach within the time period provided in the cure Section above, then TENNCARE may declare a Partial Default and provide written notice to the CONTRACTOR of the following:

(1) The date upon which the CONTRACTOR shall terminate providing the service associated with the Breach; and

(2) The date TENNCARE or its designate will begin to provide the service associated with the Breach.

TENNCARE may revise the time period contained in the notice upon written notice to the CONTRACTOR.

4-2.b.5. (b) In the event TENNCARE declares a Partial Default, TENNCARE may withhold, together with any other damages associated with the breach, from the amounts due the CONTRACTOR the greater of:

(1) Amounts which would be paid the CONTRACTOR to provide the defaulted services; or

(2) the cost to TENNCARE of providing the defaulted service, whether said service is provided by TENNCARE or a third party; and

4-2.b.5. (c) To determine the amount the CONTRACTOR is being paid for any particular service, TENNCARE shall review all relevant documents and then make a final and binding determination of said amount. The cost to TENNCARE for providing the defaulted service, when the defaulted service is the provision of a covered benefit, shall be the amount paid by TENNCARE to the provider plus an administrative fee of ten percent (10%) of the value of the claims paid.

4-2.c. 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.

4-2.d. Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy

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 minimum net worth sufficient to meet the statutory standards for licensed health maintenance organizations.

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.

4-2.e. Termination by TENNCARE for Convenience

TENNCARE may terminate this Agreement for convenience and without cause upon thirty (30) days written notice. Said termination shall not be a breach of contract 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.

4-2.f. Notice of Non-renewal by the CONTRACTOR or TENNCARE

This Agreement shall be valid for the period specified in Section 4-28 of the Agreement. Effective July 1, 2001, the CONTRACTOR or TENNCARE shall have a right to give the other written notice of non-renewal or termination on or by July 1 of each year. Effective for calendar year 2002 only, said written notice of non-renewal or termination may be given on or by July 31, 2002. Effective for calendar year 2003 only, said written notice of non-renewal or termination may be given twenty-one calendar days after the date TENNCARE provides the CONTRACTOR with written notification of the capitation payment rates that will be effective on January 1, 2004. Said notice shall either terminate or prevent the automatic renewal of the Agreement on the following December 31st. If notice of non-renewal is issued by the CONTRACTOR, said written notice must be accompanied by the binding guarantee described in Section 4-2.g subpart 15 of this Amendment, must actually be received by TENNCARE by July 1, or as provided herein, cite this provision, and must be either hand-delivered to the Bureau of TennCare with a receipt signed by the Commissioner of Finance and Administration or Director of TennCare or mailed to the Commissioner of Finance and Administration or Director of TennCare, Return Receipt Requested. The foregoing requirements for CONTRACTOR non-renewal of this subdivision (f) shall be strictly construed. The CONTRACTOR shall comply with all terms and conditions stipulated in the Agreement during the closeout period, including but not limited to Section 4-2. If notice of non-renewal is issued by TENNCARE, said written notice must be actually received by the CONTRACTOR by July 1, or as provided herein, cite this provision, and must be either hand-delivered to the CONTRACTOR or mailed to the CONTRACTOR in accordance with Section 1-1 of this Agreement. In the event that the legislature has not appropriated funding by July 1, the deadline for the notice of non-renewal or termination shall be extended to seven calendar days after the date of appropriation. Except for the circumstance described in Section 3-10.c.2(a)(6), this is the only provision allowing CONTRACTOR to unilaterally prevent renewal or otherwise terminate this Agreement.

Effective for calendar year 2004 only, should the CONTRACTOR exercise its option to give TENNCARE written notice of non-renewal by July 1 for the January 1, 2005 Agreement period, the CONTRACTOR and TENNCARE agree that the payment provisions in effect through June 30, 2004 as described in Section 3-10.h and Attachment X.D shall remain in effect through the term of the Agreement.

4-2.g. Termination Procedures

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.

Upon receipt of notice of termination or non-renewal, and subject to the provisions of Section 4-2.g, on the date and to the extent specified in the notice of termination and as directed by the State in the event of non-renewal, the CONTRACTOR shall:

4-2.g. 1. Stop work under the Agreement, but not before the termination date;

4-2.g. 2. Terminate all marketing procedures and subcontracts or provider agreements relating to marketing;

4-2.g. 3. 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;

4-2.g. 4. Complete the performance of such part shall have not been terminated under the notice of termination;

4-2.g. 5. 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;

4-2.g. 6. Continue to submit invoices for the payment of covered services as specified in Section 3-10. One hundred eighty days after the Agreement ends, the CONTRACTOR shall reasonably estimate the amount of claims remaining to be paid for medical services incurred during the Stabilization Period that were not reflected in the final invoice. If TENNCARE accepts the estimate as reasonable, TENNCARE will deposit that amount in an account for the purpose of paying run-out claims. TENNCARE will supplement the funding of the account as necessary to permit coverage of the remaining payable claims as needed.

4-2.g. 7. In the event the Agreement is terminated by TENNCARE, the CONTRACTOR shall continue to serve or arrange for provision of services to the enrollees in the plan for up to forty-five (45) calendar days from the Agreement termination date or until the enrollees can be transferred to another health plan, whichever is longer. During this transition period, TENNCARE shall continue to pay the applicable fixed administrative fee rate, and make payment for covered services as specified in Section 3-10;

4-2.g. 8. The CONTRACTOR shall promptly make available to TENNCARE, or another health plan acting on behalf of TENNCARE, any and all records, whether medical 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;

4-2.g. 9. The CONTRACTOR shall promptly supply all information necessary to TENNCARE or another health plan acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;

4-2.g. 10. 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 11. through 16.

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 25% of the CONTRACTOR's monthly fixed administrative fee payment ;

4-2.g. 11. 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;

4-2.g. 12. 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 2-8;

4-2.g. 13. The CONTRACTOR shall file all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

4-2.g. 14. The CONTRACTOR shall take whatever other actions are necessary in order to ensure the efficient and orderly transition of participants from coverage under this Agreement to coverage under any new arrangement developed by TENNCARE;

4-2.g. 15. In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, the CONTRACTOR shall 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;

4-2.g. 16. Upon expiration or termination of this Agreement, the CONTRACTOR shall 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; and

4-2.g. 17. In order for a terminated or partially terminated CONTRACTOR to resume providing terminated services, said terminated CONTRACTOR shall execute an entirely new application to participate in the TennCare program and shall execute a new Agreement.

4-3. Errors

The CONTRACTOR is expected to prepare carefully all reports for submission to TENNCARE. If after preparation and submission, a CONTRACTOR error is discovered either by the CONTRACTOR or TENNCARE, the CONTRACTOR has fifteen (15) calendar days, where practical, after written notification to correct the error and submit accurate reports and/or invoices. Similarly, errors on TENNCARE's part identified by the CONTRACTOR shall be corrected within fifteen (15) calendar days, where practical, of receipt of written notification by the CONTRACTOR.

4-4. 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.

4-5. 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, and 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.

4-6. Agreement Variation

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 obligation arising under such provisions. 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.

4-7. Conflict of Interest

4-7.a. 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 4-7 and its subparts of this contract, “immediate family member” shall mean a spouse or minor child(ren) living in the household.

4.7.a.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:

4.7.a.1.(a) 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

4.7.a.1.(b) 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.

4.7.a.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 4-7 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 4-8 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.

4.7.b 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 4-7 to all subcontracts, provider agreements and all agreements that result from the Agreement between the CONTRACTOR and TENNCARE.

4-8. Failure to Meet Agreement Requirements

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of 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 and not to exceed the fixed amount as stated below; 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.

4-8.a. Intermediate Sanctions

TENNCARE may impose any or all of the sanctions as described in Section 4-8 upon TENNCARE’s reasonable determination that the CONTRACTOR fails to comply with any corrective action plan (CAP) as described under Section 2-16, or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under this Agreement to an enrollee covered under the Agreement.
- Imposes on enrollees cost share responsibilities that are in excess of the cost share responsibilities permitted by TENNCARE.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.
- Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations.

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 or numerous.

Intermediate sanctions may include:

4-8.a. 1. liquidated damages as described in Section 4-8.b;

4-8.a. 2. suspension of enrollment in the CONTRACTOR's MCO as described in Section 2-16;

4-8.a. 3. disenrollment of enrollees as described in Section 2-22 and 3-7;

4-8.a. 4. limitation of the CONTRACTOR's Service Area as described in Section 2-22 and 3-7;

4-8.a. 5. Civil monetary penalties in as described in 42 CFR 438.704;

4-8.a. 6. Appointment of temporary management for an MCO as provided in 42 CFR 438.706.

4-8.a. 7. Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;.

4-8.a. 8. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.

4-8.a. 9. 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

4-8.a. 10. Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

4-8.b. Liquidated Damages

4-8.b.1. Reports and Deliverables

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 $100 per work day per report or deliverable. Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc or on-request reports involving provider network information), or deficient deliverables shall begin on the sixteenth day after notice is provided from TENNCARE to the CONTRACTOR that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of ad hoc or on-request reports involving provider network information, liquidated damages for incorrect reports shall begin on the first day the report is determined by TENNCARE to be incorrect. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the following schedule, unless otherwise specified elsewhere in this Agreement:

DELIVERABLES		**DATE AGREED UPON BY THE PARTIES**
Daily Reports		Within two (2) working days.
Weekly Reports		Wednesday of the following week.
Monthly Reports		20th of the following month.
Quarterly Reports, excluding SURS		30th of the following month.
Semi-Annual Reports		January 31 and July 31.
Annual Reports		Ninety (90) calendar days after the end of the year.
On Request Reports		Within three (3) working days from the date of request when reasonable unless otherwise specified by TENNCARE.
Ad Hoc Reports		Within ten (10) working days from the date of the request when reasonable unless otherwise specified by TENNCARE.

4-8.b.2. Program Issues

Liquidated damages for failure to perform specific responsibilities as described in this Agreement are shown below. Damages are grouped into three categories: **Class A** violations, **Class B** violations, and **Class C** violations.

Class A violations are those which pose a significant threat to patient care or to the continued viability of the TENNCARE program.

Class B violations are those with pose threats to the integrity of the TENNCARE program, but which do not necessarily imperil patient care.

Class C violations 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.

CLASS	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in Section 2-2.h and 2-9.m 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 2-2.h and 2-9.m of this Agreement.
A.2	Failure to comply with licensure requirements in Section 2-9.d 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 as described in Section 2-3.c.1 of this Agreement		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater, to be deducted from monthly fixed administrative fee payments.
A.4	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater, to be deducted from monthly fixed administrative fee payments.
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, to be deducted from monthly fixed administrative fee payments.
A.6	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE 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 a plan's demonstration of good cause.		$500 per day beginning on the next calendar day after default by the plan in addition to the cost of the services not provided.

CLASS	PROGRAM ISSUES		DAMAGE
A.7	Failure to provide proof of compliance to the Bureau Office of Contract Compliance and Performance 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 a plan's demonstration of Good Cause.		$500 per day beginning on the next calendar day after default by the plan.
A.8	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2-3.o of this Agreement		$500 per violation or the actual amount of the federal penalty created by this violation, whichever is greater.
A.9	Failure to provide coverage for prenatal care without a delay in care and in accordance with the terms of this Agreement		$500 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Agreement.
A.10	Failure to comply with the notice requirements of the TENNCARE rules and regulations or any subsequent amendments thereto, and all court orders 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 provide continuation or restoration of services where enrollee was receiving the service as required by the TENNCARE rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders 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.12	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.

CLASS	PROGRAM ISSUES		DAMAGE
A.13	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.14	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.
A.15	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.)

CLASS	PROGRAM ISSUES		DAMAGE
A.16	Systemic violations regarding any aspect of the requirements in accordance with this Agreement and the TennCare rules and regulations.		First occurrence: $500 per instance of such systemic violations, even if damages regarding one or more particular instances have been assessed. Damages per instance shall increase in $500 increments for each subsequent systemic violation ($500 per instance the first time a systemic violation relating to a particular requirement is identified; $1,000 per instance for the 2nd time a systemic violation relating to the same requirement is identified; etc.)
A.17	Failure to adhere to ED guidelines as described in Section 2-3.s.5 of this Agreement.		$1000 per occurrence for each failure to enroll a member identified per 2-3.s.5 in active case management. $5000 per occurrence for each failure to assist a member in arranging care in an alternative setting per 2-3.s.5 (g) or (h).
A.18	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 or 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 MCC fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service.
B.1	Failure to report Specialty listings to PCP providers as required by 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.

CLASS	PROGRAM ISSUES		DAMAGE
B.3*	Failure to comply with the approved expenditure plan in effect after July 1, 1999 as required by Section 3-10.b of the Contractor Risk Agreement dated September 11, 1995 in accordance with Section 1-7 and Attachment XIV of this Agreement.		$15,000 per calendar day for each calendar day of non-compliance plus the amount that was not expended as required by the approved expenditure plan.
B.4	Failure to seek, collect and/or report third party recoveries to TENNCARE.		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries.
B.5	Deadlines for Achieving NCQA Accreditation.		Termination of the Agreement for Breach as described in Section 4-2 for consistent failure to meet the deadlines described in Section 2-9.j.7 of this Agreement.
B.6	Failure to submit Audited HEDIS and CAHPS Reports Annually by June 15th as described in Section 2-9.j.7 and 2-10.m.4.		$250 per day for every calendar day reports are late.
B.7	Failure to submit NCQA Accreditation Report as described in Sections 2-9.j.7 and 2-10.m.6.		$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported.
B.8	Failure to comply with Conflict of Interest, Lobbying, and Gratuities requirements described in Section 4-7, 4-11 or 4-12.		110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals as described in Section 4-7, 4-11 or 4-12 and possible termination of the Agreement as described in 4-7, 4-11 or 4-12.
B.9	Failure to submit TennCare Disclosure of Lobbying Activities Form by CONTRACTOR		$1000.00 per day that disclosure is late
B.10	Failure to comply with Offer of Gratuities constraints described in Section 4-11		110 % of the total benefit provided by the CONTRACTOR to inappropriate individuals and possible termination of the Agreement for Breach as described in 4-2 of this Agreement.

CLASS	PROGRAM ISSUES		DAMAGE
B.11	Failure to obtain approval of Marketing Materials.		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided enrollee material that has not been approved by TENNCARE.
B.12	Failure to comply with Marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories, and Newsletters.		$5000 for each occurrence.
B.13	Failure to achieve and/or maintain financial reserves in accordance with TCA.		$500 per calendar day for each day that financial requirements have not been met.
B.14	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.10.h.2.		$500 per calendar day.
B.15	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.10.h.3.		$500 per calendar day.
B.16	Failure to submit audited financial statements as described in Section 2.10.h.4.		$500 per calendar day.
B.17	Failure to comply with fraud and abuse provisions as described in Section 1-5 of this Agreement.		$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions described in Section 1-5 of this Agreement.
B.18	Failure to send collection notices to providers as described in 2-10.e.3(a) of this Agreement.		$100 per provider notice per month.
B.19	Failure to send detailed reports to TENNCARE as described in 2-10.e.3(b), (c) and (d) of this Agreement.		$500 per day for each day that report is late.

CLASS	PROGRAM ISSUES		DAMAGE
B.20	Failure to require and assure compliance with Ownership and Disclosure requirements.		$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.21	Failure to maintain a complaint and appeal system as required in Section 2-8 of this Agreement.		$500 per calendar day
B.22	Failure to maintain required insurance as required in Section 2-20 of this Agreement.		$500 per calendar day
B.23	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.-3.a.3 and 2-3.s of this Agreement.		$500 per occurrence.
B.24	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application as required in Section 2-3.k.6 and 2-9.j.6 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/Or $1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been completed as described in Section 2-3.k.6 and 2-9.j.6 of this Agreement.
B.25	Failure to maintain provider agreements in accordance with Section 2-18 of this Agreement.		$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 2-18 of this Agreement.
C.1	Failure to comply in any way with staffing requirements as described in Section 2-9.c of this Agreement.		$250 per calendar day for each day that staffing requirements as described in Section 2-9.c of this Agreement are not met.

CLASS	PROGRAM ISSUES		DAMAGE
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's plan.		$200 per day.
C.3	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.4	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 2-6.a.12		$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

*Applicable only to MCOs with an executed Agreement as of July 1, 1999

4-8.b.3. Payment of Liquidated Damages

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 and if payment is not made by the due date, said liquidated damages may be withheld from future fixed administrative fee payments by TENNCARE without further notice. 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 Class B and Class C violations, 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.

Liquidated damages as described in Section 4-8 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.

All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the CONTRACTOR out of administrative costs and profits.

4-8.b.4. Waiver of Liquidated Damages

TENNCARE may waive the application of liquidated damages and/or withholds upon a managed care organization that is placed in rehabilitation or under administrative supervision if it is deemed in the best interests of the TennCare program and its enrollees.

4-8.c. Claims Processing Failure

If it is determined that there is a claims processing deficiency related to the MCO's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section 2-9.m, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of intermediate sanctions specified in Section 4-8 and the retention of withholds as specified in Section 3-10. 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 CONTRACTOR agrees the State may terminate this Agreement in accordance with Section 4-2.b of this Agreement.

4-8.d. Failure to Manage Medical Costs

If TENNCARE determines the CONTRACTOR is unable to successfully manage medical costs, TENNCARE may terminate this Agreement with ninety (90) days advance notice in whole or in part, immediately or in stages in accordance with Section 4-2.b of this Agreement.

4-8.e. 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.

4-8.f. Temporary Management

TENNCARE shall 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.

4-9. Renegotiation Procedures

Renegotiation procedures and criteria for amending this Agreement shall be as follows:

a. For good cause, only at the end of the contract period; and

b. For modification(s) during the contract period, if circumstances warrant.

This Agreement may be amended at anytime as provided in this paragraph. This Agreement shall be amended automatically without action by the parties whenever required by changes in state and federal law or regulations. In the event of a Partial Default, the Agreement shall be amended automatically to conform with written notices from TENNCARE of the CONTRACTOR regarding the effect of the Partial Default upon this Agreement. No other modification or change of any provision of the Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by the CONTRACTOR and TENNCARE and incorporated as a written amendment to this Agreement prior to the effective date of such modification or change.

4-10. Titles

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

4-11. Offer of Gratuities

By signing this Agreement, the CONTRACTOR signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. 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, his agent, or employees and may result in termination of the Agreement and/or liquidated damages as provided in Section 4-8.b.2 (B.8) of this Agreement.

4-12. Lobbying

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.).

The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in 4-8.b.2 (B.8 and B.99) of this Agreement.

4-13. Inspection of Work Performed

TENNCARE or its authorized representative 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.

4-14. 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.

4-15. Court of Jurisdiction or Venue

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.

4-16. 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.

4-17. 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.

4-18. 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 will be

responsible for insuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of health care. The failure of the CONTRACTOR's fiscal intermediary to perform any requirements of this Agreement shall not be considered a 'force majeure'.

4-19. 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 T.C.A. Section 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 T.C.A. Section 9-8-301, et. seq.

4-20. Indemnification

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 T.C.A. Section 8-6-106.

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 copy rights 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 T.C.A. Section 8-6-106.

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 the failure of the State to meet its obligations under the Agreement.

4-21. Non-Discrimination

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 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. The CONTRACTOR shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

4-22. Confidentiality of Information

The CONTRACTOR shall assure that all material and information, in particular information relating to enrollees or potential enrollees, which is provided to or obtained by or through the CONTRACTOR's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported 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.

All information as to personal facts and circumstances concerning enrollees or potential enrollees 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 enrollee/potential enrollee, 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 enrollees/potential enrollees shall be limited to purposes directly connected with the administration of this Agreement.

4-23. Rate Adjustment

The CONTRACTOR and TENNCARE agree that the fixed administrative rate(s) described in Section 3-10 of this Agreement may be increased periodically. The CONTRACTOR and TENNCARE further agree that adjustments to the fixed administrative rate(s) required pursuant to this Section shall occur only by written amendment to this Agreement. If significant changes are made in the scope of services under the TennCare Program (other than EPSDT mandated services as provided by this Agreement), as mandated by actions of the Congress, the State, the State Legislature, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS) or any agency of the state government, the Bureau of TENNCARE shall review and adjust the Medical Fund Target specified in Section 3-10 accordingly subject to the availability of State appropriations for the mandate.

In the event the amount of the two percent 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.

4-24. 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 the Tennessee Department of Commerce and Insurance. The parties acknowledge that no action by the Department of Commerce and Insurance 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 T.C.A. Section 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.

4-25. 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 and 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.

4-26. 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.

4-27. Exigency Extension

At the option of the State, the CONTRACTOR agrees to continue services for the Department when the Department determines that there is a public exigency that requires the contracted 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) days notice shall be given by the Department before this option is exercised.

During any periods of public exigency, TENNCARE shall continue to reimburse the CONTRACTOR at the rates specified in Section 3-10.h of this Agreement.

4-28. Term of the Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements except as stated in Section 1-7. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2008 unless the CONTRACTOR or the State complies with Section 4-2.(f) regarding non-renewal or unless the State approves termination of the Agreement in accordance herewith. Said renewal shall be automatic and shall not require any notice or other action.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
C. Warren Neel
Commissioner

DATE: _____

COMPANY NAME

BY: _____
NAME
TITLE

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
C. Warren Neel
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
John G. Morgan
Comptroller

DATE: _____

ATTACHMENTS

ATTACHMENT I - DELIVERABLE REQUIREMENTS

ATTACHMENT I
DELIVERABLE REQUIREMENTS

The CONTRACTOR and TENNCARE are responsible for complying with all the deliverable requirements established by the parties. Both parties are responsible for assuring the accuracy and completeness of all deliverables as well as the timely submission of each deliverable. Both parties will agree to the appropriate deliverable instructions, submission timetables, and technical assistance as required.

I. Items requiring prior approval by TENNCARE

A.	Fraud and Abuse Compliance Plan	TENNCARE has thirty (30) calendar days to respond
B.	Provider Network	TENNCARE has thirty (30) calendar days to respond
C.	Drug Formulary (if closed) (Effective July 1, 2003, the TENNCARE shall contract directly with a pharmacy benefits manager for pharmacy services as described in Section 2-3.a.1 of this Agreement.)	TENNCARE has thirty (30) calendar days to respond
D.	EPSDT Policies and Procedures, including but not limited to: • Provider referral procedures for enrollees requiring further care • Appropriate record keeping • Follow- up process for enrollees who do not receive timely screenings	TENNCARE has thirty (30) calendar days to respond
E.	Marketing/Enrollee Materials and/or Plans	TENNCARE has fifteen (15) calendar days to respond
F.	Subcontracts	TENNCARE has thirty (30) calendar days to respond
G.	Indemnity language in provider agreements if different than standard indemnity language	TENNCARE has fifteen (15) calendar days to respond
H.	Quality Monitoring/Quality Improvement Process including but not limited to: ▪ Annual QIPD and UMPD plus associated work plans ▪ Annual evaluation ▪ QIAs ▪ Disease Management Programs	TENNCARE has thirty (30) calendar days to respond

I.	Insurance and Bonding Plans	TENNCARE has fifteen (15) calendar days to respond
J.	Method of pharmacy restriction procedures for Pharmacy Abusers Effective July 1, 2003, the TENNCARE shall contract directly with a pharmacy benefits manager for pharmacy services as described in Section 2-3.a.1 of this Agreement At such time, the CONTRACTOR shall comply with TennCare Policy regarding Pharmacy Abusers.	TENNCARE has thirty (30) calendar days to respond
K.	MCO/BHO Coordination Agreement	TENNCARE has thirty (30) calendar days to respond
L.	Termination Plan	TENNCARE has thirty (30) calendar days to respond
M.	Written Binding Guarantee from a financially viable entity of all debts incurred in the amount of $4.5 million or the minimum net worth required to be maintained by a health maintenance organization operating under a Certificate of Authority in the State of Tennessee, whichever is greater	TENNCARE has twenty (20) calendar days to respond

II. Deliverables which are the responsibility of the CONTRACTOR

A	Listing of referral providers in accordance with Section 2-3.j.3(e)	Due to providers within thirty (30) days following the execution of this Agreement and quarterly thereafter on a calendar year schedule. Proof of compliance shall be sent to the Office of Contract Development and Compliance by the 30th of the month following each quarter.
B	FQHC Reporting in accordance with 2-3.n. and 2-10.k	Due January 1 of each year to Office of Fiscal Services and Provider Networks
C	Complete Drug Formulary; if CONTRACTOR utilizes a closed drug formulary, and a complete description of prior authorization criteria for each drug requiring prior authorization via electronic file in accordance with Section 2-3.q (Effective July 1, 2003, the TENNCARE shall contract directly with a pharmacy benefits manager for pharmacy services as described in Section 2-3.a.1 of this Agreement.)	January 1 of each year to TENNCARE Pharmacy Director
D	Quarterly Newsletter in accordance with Section 2-5.b.2	Due quarterly, within one hundred twenty (120) days of the prior quarters' newsletter to enrollees and to the Office of Contract Development and Compliance (10 copies)
E	Identify key staff contacts in accordance with Section 2-9.c and 2-10.i	Due within thirty (30) days of Agreement execution and within ten (10) business days of any changes to the Office of Contract Development and Compliance
F	Clinical and Service Quality Improvement Activity Forms in accordance with Section 2-9.j.2	Annually, by April 15th of each calendar year to the Office of TENNCARE
G	Return of funds, in accordance with 2-9.k.3	Thirty (30) calendar days following notification
H	Enrollee Information as described in Section 2-10.b.1	Weekly, by Wednesday of the following week to TENNCARE, Information Systems Section
I	Eligibility and Premium reconciliation as described in Section 2-10.b.3	Quarterly, by the 30th of the following month to the TENNCARE Information Systems Section
J	Enrollee Cost-Sharing in accordance with Section 2-10.b.4	Quarterly, by the 30th of the following month to TennCare Information Systems Section
K	Provider Enrollment listing in	Monthly, within five (5) working days following

	accordance with Section 2-10.c	the end of the month, to the TennCare Information Systems Section
L	Unduplicated listing of all providers and their unique identifying provider numbers cross-referenced to the Medicaid servicing provider number in accordance with Section 2-10.c	Within ten (10) working days of a request by TENNCARE to the TennCare Information Systems Section
M	Listing of Essential Hospital Providers in the MCO's provider network in accordance with Section 2-10.c.2	By September 1 of each year to the Office of Fiscal Services and Provider Networks
N	Listing of Specialty Physician Arrangements in accordance with Section 2-10.c.3	Within sixty (60) calendar days of Agreement execution, thereafter by September 1 of each year
O	Reporting Other Insurance in accordance with Section 2-10.d	To be Determined
P	Individual Encounter Reporting in accordance with 2-10.e.1	Monthly, by the 15th of the following month, to TENNCARE, Information Systems Section
Q	Monthly Activity Reporting in accordance with Section 2-10.f	Quarterly by the thirtieth (30th) of the following month to Office of Contract Development and Compliance
R	Network Clearing House Reporting in accordance with Section 2-10.g	At TENNCARE's request
S	Annual Report - Submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 2-10.h	Due on or before March 1 of each calendar year to The Department of Commerce and Insurance, TennCare Division
T	Quarterly Financial Report - Submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 2-10.h	Due on or before June 1, September 1, and December 1 in accordance with Section 2-10.h of this Agreement to be submitted to The Department of Commerce and Insurance, TennCare Division
U	Audit of Business Transactions/ Audited Financial Statements in accordance with Section 2-10.h	Due on or before May 1 of each calendar year to The Department of Commerce and Insurance, TennCare Division
V	Board of Directors in accordance with Section 2-10.i	At the beginning of the Agreement period and within ten (10) business days of a change to Office of Contract Development and Compliance
W	Quality Improvement Reports, Annual Review of the Quality	Annually, by April fifteenth (15th) to TENNCARE

	Improvement Program Description, Utilization Management Program Description, associated Work Plans and Annual Evaluation of QI and UM Programs in accordance with 2-9.j and 2-10.m.1.	
X	QIA Update Grid in accordance with 2-9.j.2 and 2-10.m.2	Within thirty (30) calendar days of the end of the quarter to TENNCARE
Y	QI Reports – PCP Assignment Reporting in accordance with 2-10.m.3	Within thirty (30) calendar days of the end of the quarter to TENNCARE
Z	All required QM/QI reports in accordance with 2-9 and 2-10	As specified, to TENNCARE
AA	Audited HEDIS and CAHPS results, including audit report/findings.	Annually by June 15th to TENNCARE
BB	NCQA accreditation survey report	Immediately upon receipt, no later than ten (10) calendar days of notification from NCQA, to TENNCARE
CC	NCQA's annual reevaluation of accreditation status based on HEDIS score	Immediately upon receipt, no later than ten (10) calendar days of notification from NCQA to TENNCARE
DD	Notification of resurvey by NCQA	Immediately upon receipt, no later than ten (10) calendar days of notification from NCQA to TENNCARE
EE	EPSDT Report	Quarterly to TENNCARE by the end of the month following the end of each quarter
FF	Cost and Utilization Summaries in accordance with 2-10.n	As specified at 2-10.n
GG	Cost and Utilization Reports in accordance with 2-10.o	As specified at 2-10.o
HH	Network Management Reports in accordance with 2-10.p	As specified at 2-10.p
II	HIPAA Reporting in accordance with 2-10.q, 2-3.w and 2-10.a	As specified at 2-10.q
JJ	Prior Authorization Summary in accordance with Section 2-10.r	Monthly, by the 20th of the following month to TENNCARE
KK	Written plan of changes resulting from monitoring and audit in accordance with Section 2-16	Within fifteen (15) working days after receipt of notice of deficiencies to the Office of Contract Development and Compliance, unless otherwise specified in the request from TENNCARE

LL	Ownership and Financial Disclosure in accordance with Section 2-21	With Agreement, and annually thereafter by March 1 of every year to the Office of Contract Development and Compliance
MM	Significant business transaction in accordance with Section 2-21	Upon Occurrence to the Department of Commerce and Insurance, TennCare Division
NN	Annual submission of personnel/ operational policies that emphasize non-discrimination in hiring, promotional and contracting processes as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Director of Non-discrimination Compliance/ Health Care Disparities
OO	Quarterly listing of complaints filed alleging discrimination as described in Section 2-24	Quarterly, by the 30th of the following month to the Director of Non-discrimination Compliance/Health Care Disparities
PP	Quarterly listing of supervisory personnel as described in Section 2-24	Quarterly, by the 30th of the following month to the Director of Non-discrimination Compliance/Health Care Disparities
QQ	Annual listing by CSA of non-institutional providers as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Director of Non-discrimination Compliance/Health Care Disparities
RR	Annual copy of CONTRACTOR's policy regarding non-discrimination of services to persons with Limited English Proficiency as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Director of Non-discrimination Compliance/Health Care Disparities
SS	On a Quarterly basis, a listing of all request of translation or interpreter services as described in Section 2-24.g.1.	Quarterly, by the 30th of the following month to the Director of Non-discrimination Compliance/Health Care Disparities
TT	Annual Compliance Plan as described in Section 2-24	On an annual basis to the Director of Non-discrimination Compliance/Health Care Disparities

III. Deliverables which are the responsibility of TENNCARE

A. Reports concluding findings, recommendations and requirements resulting from monitoring procedures by TENNCARE and/or HCFA.

B. Updated eligibility information in the form of electronic submissions.

C. Medicare/TennCare dual eligible pharmacy information monthly. Effective July 1, 2003, all TennCare covered pharmacy services shall be provided through a TennCare contracted pharmacy benefits manager (PBM). At such time, all pharmacy information shall be provided monthly.

D. Notice of any consent decree entered into by the State within 72 hours of the decree being entered with court and notice of other court orders affecting MCO participation in the TennCare Program within seventy-two (72) hours of receipt in the Attorney General's Office.

E. Notice of any enrollees who have exceeded the out-of-pocket maximum for whom the MCO must coordinate reimbursement on a schedule to be specified by TENNCARE.

ATTACHMENT II – ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

ATTACHMENT II

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 III - TERMS AND CONDITIONS FOR ACCESS

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 3.

    + 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 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
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000

ATTACHMENT V - INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT FORM

INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT FORM

1. Enrollee's TennCare Identification Number may be typed, handwritten or left blank.

2. The physician's name, group name or clinic name from whom the enrollee received information about the sterilization procedure. This can be typed or handwritten.

3. Type of sterilization operation to be performed on the enrollee. This can be typed or handwritten.

4. Enrollee's date of birth. The enrollee must be twenty-one (21) years old to sign the sterilization consent form. This can be typed or handwritten.

5. Enrollee's name. This can be typed or handwritten.

6. Physician's name, group name, or clinic if the enrollee is not sure who will be performing the sterilization procedure. This physician does not have to be the same physician who performed the surgery. This can be typed or handwritten.

7. Type of sterilization procedure to be performed. This can be typed or handwritten.

8. Signature of enrollee. The enrollee must simultaneously sign his/her name and date in his/her own handwriting. If the enrollee cannot sign his/her name he/she can make his/her mark "X" in enrollee's signature if there is a witness. The witness must sign down below his/her name and simultaneously date the day they witnessed the enrollee make their mark. This must be in the witness' own handwriting. The witness should write witness beside their name.

9. The enrollee must simultaneously write the date he/she signed the consent form in their own handwriting when signing the consent form.

10. The enrollee should write in the time they signed the consent form. This is only important in cases where the thirty (30) day time period has not lapsed and the 72 hour period between the time the enrollee signed the consent form and the time the sterilization procedure was performed.

11. Race and ethnicity designation is optional.

12. The language used to explain the consent form if an interpreter is used. This can be typed or handwritten.

13. Signature of the interpreter and the date the interpreter signs the consent form. The interpreter must sign his/her name and simultaneously write the date in his/her own handwriting. If an interpreter is not used write NA in the blanks.

14. Name of the individual to be sterilized. This can be typed or handwritten.

15. Type of sterilization operation to be performed. This can be typed or handwritten.

16. Signature of the person obtaining consent and the date he/she signed the consent form. The person who obtained consent must sign and date the consent form simultaneously in his/her own handwriting. The signature of the person obtaining consent and the date must be signed prior to surgery.

17. Name of the facility where the person obtaining consent is located. This can be typed or handwritten.

18. Address of the facility. This can be typed or handwritten.

19. Name of the individual to be sterilized. This can be typed or handwritten.

20. The exact date the sterilization was performed. The date can be typed or handwritten. The date of service on the claim requesting payment must be the same date on the sterilization consent form.

(A) Thirty (30) calendar days must have lapsed between the date the enrollee signed the consent form and the date the sterilization procedure was performed. Start counting day one (1) the day after the enrollee signs the consent form and then the sterilization can be performed on the 31st day except in the case of premature delivery or emergency abdominal surgery.

(B) In case of premature delivery, at least 72 hours must have passed between the day and time the enrollee signed the consent form before the sterilization procedure can be performed. At least thirty (30) calendar days would have had to lapse between the date the enrollee signed the consent form and the individual's expected date of delivery.

(C) In the case of emergency abdominal surgery, at least 72 hours must have passed between the day and time the enrollee signed the consent form before the sterilization procedure can be performed.

(D) The consent form expires 180 calendar days from the date of the enrollee's signature. Start counting the date the enrollee signed the consent form as day one (1). The procedure must be performed within 180 calendar days.

21. Type of sterilization operation performed. This can be typed or handwritten.

22. Alternative final paragraph instructions:

(A) Cross out paragraph two (2) if at least thirty (30) calendar days have lapsed between the date of the enrollee's signature on the consent form and the date the sterilization operation was performed.

(B) Cross out paragraph one (1) if this sterilization was performed less than thirty (30) calendar days but more than 72 hours after the date of the enrollee's signature on the consent form because of premature delivery or emergency abdominal surgery. Check appropriate boxes for premature delivery and individual expected date of delivery and fill in the enrollee's expected date of delivery. Or if emergency abdominal surgery check appropriate box and describe circumstances.

23. Physician's signature. The physician who performed the sterilization procedure must sign his/her name and date he/she signed the consent form simultaneously in his/her own handwriting. The physician must sign the consent form after surgery. The physician's signature, date and time must be in his/her own handwriting. Typed or stamped signatures, initials or dates are not acceptable.

(A) If the physician signs the consent form the same day as surgery then he/she must specify what time he/she signed the consent form.

(B) If the physician signs the consent form the same day as surgery and signs the time he/she signed the consent form as 8:00 a.m. or earlier the time surgery ended must be specified below on the consent form.

(C) If the physician signs the consent form the day after surgery or later then the time the physician signed the consent form may be left blank.

MEDICAID-TITLE XIX **STERILIZATION CONSENT FORM**

_____
Recipient Medicaid Number

INSTRUCTIONS: COMPLETE AND ATTACH TO CLAIM FORM WHEN SUBMITTING CLAIM FOR PAYMENT.

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____
(Doctor or Clinic)

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

_____

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not be sterilized will not result in the withholding of any benefits of medical services provided by federally funded programs.

I am at least 21 years of age and was born on

_____
(Month, Day, Year)

I, _____ hereby consent of my own free will to be sterilized by

_____
(Doctor)

by a method called _____

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature of Recipient Month Day Year

Time Signed: _____ AM PM

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin)
☐ Asian or Pacific Islander ☐ Hispanic
☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized.

I have translated the information and advice presented orally to the individual to be sterilized by a person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Signature of Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed
Name of individual

The consent form, I explained to him/her the nature of the sterilization operation

_____

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ on _____
Name of individual to be sterilized Date of sterilization

I explained to him/her the nature of the sterilization operation

_____
Specify type of operation

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Instructions for use of alternative final paragraphs:

Use the first paragraph below except in case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization operation was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature in this consent form because of the following circumstances (check applicable box and fill in information request):

☐ Premature delivery
☐ Individual's expected date of delivery _____
☐ Emergency abdominal surgery
(describe circumstances)

_____
Physician's Signature

Time of Signature _____ AM PM Date of Signature _____

MEDICAID-TÍTULO XIX FORMULARIO DE CONSENTIMIENTO PARA ESTERILIZACIÓN

_____
Número de Medicaid del receptor

INSTRUCCIONES COMPLETE Y ADJUNTE AL FORMULARIO DE RECLAMACIÓN CUANDO ENVÍE EL RECLAMO PARA SU PAGO.

AVISO: SU DECISIÓN, EN CUALQUIER MOMENTO, DE NO SER ESTERILIZADO, NO TENDRÁ COMO CONSECUENCIA EL QUE SE LE RETIRE O SE LE NIEGUE NINGUNO DE LOS BENEFICIOS PROPORCIONADOS POR CUALQUIER PROGRAMA O PROYECTO QUE RECIBA FONDOS FEDERALES

CONSENTIMIENTO PARA ESTERILIZACIÓN

He pedido y he recibido información sobre la esterilización de

_____
(Doctor o clínica)

Cuando pedí la información, se me dijo que la decisión de practicarme la esterilización es totalmente mía. Se me dijo que podría decidir que no se me esterilice. Si decido que no se me esterilice, mi decisión no afectará mi derecho a cuidado o tratamiento en el futuro. No perderé ninguna de las ayudas y beneficios de programas que reciben fondos federales, como A.F.D.C. o Medicaid, que esté recibiendo actualmente o a los que podría tener derecho.

ENTIENDO QUE LA ESTERILIZACIÓN SE DEBE CONSIDERAR COMO **PERMANENTE** Y **NO REVERSIBLE.** HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, DAR A LUZ NI ENGENDRAR NIÑOS.

Se me ha informado acerca de aquellos métodos temporales de control natal que están disponibles y que se me podrían proveer, los cuales me permitirían dar a luz o engendrar un niño en el futuro. He rechazado estas alternativas y he escogido que se me esterilice.

Entiendo que se me va a esterilizar mediante una operación conocida como

_____

Se me han explicado las incomodidades, riesgos y beneficios relacionados con la operación. Todas mis preguntas han sido contestadas a mi entera satisfacción.

Entiendo que la operación no se llevará a cabo sino hasta que hayan transcurrido treinta días de la fecha en que firme este documento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no se me practique la esterilización no tendrá como consecuencia el que se me niegue ningún beneficio de los servicios médicos que se prestan bajo programas con fondos federales.

Tengo por lo menos 21 años de edad y nací el

_____
(Mes, día y año)

Yo, _____, por este medio doy mi consentimiento, por mi propia voluntad, para ser esterilizado por

_____
(Doctor)

mediante un método llamado _____

Mi consentimiento caduca 180 días después de la fecha de mi firma abajo.

También doy mi consentimiento para que se entregue este documento y otros documentos sobre la operación a:

Representantes del Departamento de Salud, Educación y Bienestar (*Department of Health, Education and Welfare*) y a los empleados de programas o proyectos financiados por dicho Departamento, pero sólo para determinar si se acataron las leyes federales.

He recibido copia de este formulario.

_____ Fecha _____
Firma del receptor Mes/día/año

Hora _____ AM PM

Se le solicita que provea la siguiente información, aunque no es obligatorio.

Raza y origen étnico (por favor marque)

☐ Indio Americano o Nativo de Alaska ☐ Negro (sin ser de origen hispano)
☐ Asiático o isleño del Pacífico ☐ Hispano
☐ Blanco (sin ser de origen Hispano)

DECLARACIÓN DEL INTÉRPRETE

(Si es que se ha proveído un intérprete para que asista al individuo a ser esterilizado.)

He traducido la información y consejos que fueron presentados oralmente al individuo a ser esterilizado por la persona que ha obtenido este consentimiento. También le he leído el formulario de consentimiento en el idioma _____ y le he explicado su contenido. A mi saber y entender, esta persona ha entendido esta explicación.

_____
Firma del intérprete Fecha

DECLARACIÓN DE LA PERSONA QUE OBTUVO EL CONSENTIMIENTO

Antes de que _____ firmara
(Nombre del individuo)

el formulario de consentimiento, le expliqué la naturaleza de la operación de esterilización

_____,

el hecho de que se trata de un proceso final e irreversible, así como las incomodidades, riesgos y beneficios relacionados con él.

He informado al individuo a ser esterilizado que existen métodos alternos de control natal, los cuales son temporales. Le he explicado que la esterilización es diferente porque es permanente.

He informado al individuo a ser esterilizado que su consentimiento puede ser retirado en cualquier momento y que no perderá ningún servicio o beneficio de salud financiado con fondos federales.

A mi saber y entender, el individuo a ser esterilizado tiene al menos 21 años de edad y aparenta tener competencia mental. Esta persona ha solicitado, a sabiendas y voluntariamente, ser esterilizad y parece entender la naturaleza y consecuencias del procedimiento.

_____
Firma de la persona que obtiene el consentimiento Fecha

_____
Centro

_____
Dirección

DECLARACIÓN DEL MÉDICO

Poco antes de practicar una operación de esterilización a

_____ el _____,
Nombre del individuo a ser esterilizado Fecha de la esterilización

le expliqué la naturaleza de la operación de esterilización

_____,
Especifique el tipo de operación

el hecho de que se trata de un proceso final e irreversible, así como las incomodidades, riesgos y beneficios relacionados con él.

He informado al individuo a ser esterilizado que existen métodos alternos de control natal, los cuales son temporales. Le he explicado que la esterilización es diferente porque es permanente.

He informado al individuo a ser esterilizado que su consentimiento puede ser retirado en cualquier momento y que no perderá ningún servicio o beneficio de salud financiado con fondos federales.

A mi saber y entender, el individuo a ser esterilizado tiene al menos 21 años de edad y aparenta tener competencia mental. Esta persona ha solicitado, a sabiendas y voluntariamente, ser esterilizada y parece entender la naturaleza y consecuencias del procedimiento.

Instrucciones para el uso de los párrafos finales alternativos:

Use el primero de los párrafos que siguen, excepto en el caso de parto prematuro o de cirugía abdominal de emergencia en la que la esterilización se llevó a cabo menos de 30 días tras la fecha en que el individuo firmó el formulario de consentimiento. En dichos casos, se debe usar el segundo de los párrafos que siguen. Tache el párrafo que no aplique.

(1) Han pasado al menos treinta días entre la fecha en que el individuo firmó este consentimiento, y la fecha en que se llevó a cabo la operación de esterilización.

(2) Esta esterilización se llevó a cabo menos de 30 días, pero más de 72 horas, después de la fecha en que el individuo firmó este consentimiento, debido a las siguientes circunstancias (marque el cuadro que aplique y llene la solicitud de información):

☐ Parto prematuro
☐ Fecha esperada de alumbramiento _____

☐ Cirugía abdominal de emergencia
(describa las circunstancias)

_____

Firma del médico

Hora de firma _____ AM PM Fecha de firma _____

ATTACHMENT VI - INSTRUCTIONS FOR COMPLETING "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION"

ATTACHMENT VI

INSTRUCTIONS FOR COMPLETING
"CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION"

1. Date of Service: The date the abortion was performed. This can be typed or handwritten.

2. Patient's Full Name: The name of the Mother can be typed or handwritten.

3. Patient's Social Security Number: Mother's Social Security Number can be typed or handwritten.

4. Condition: Mark the block indicating the applicable reason for the abortion. This can be typed or handwritten.

5. Supporting Documentation: Mark the block that applies to the type of supporting documentation. This can be typed or handwritten.

6. Patient Address: Patient’s complete address. This can be typed or handwritten.

7. Physician Signature: The physician must sign his/her name in his/her own handwriting.

8. Physician Name, Social Security Number and Address: The physician's name, Social Security Number and complete address. This can be typed or handwritten.

ATTACHMENT VI

CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

DATE OF SERVICE: _____1_____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____2_____

Patients' Social Security Number: __ __ __ - __3__ - __ __ __ __

for the following reason:

(CHECK ONE) **4**

( ) There is credible evidence to believe the pregnancy is the result of rape or incest.

( ) The abortion is medically necessary as the 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 place the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION: **5**

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

( ) Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.

( ) Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.

( ) Medical records documenting the life saving nature of the abortion.

( ) Other (Please Specify): _____

PATIENT ADDRESS:

_____6_____
_____
_____

PHYSICIAN PERFORMING ABORTION:

SIGNATURE: _____7_____
PHY. NAME: _____8_____
PHY. SS#: __ __ __-__ __-__ __ __ __
PHY. ADD.: _____
_____
_____
_____

CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

DATE OF SERVICE: _____ __ _____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____

Patients' Social Security Number: __ __ __ - __ __ - __ __ __ __

for the following reason:

(CHECK ONE)

( ) There is credible evidence to believe the pregnancy is the result of rape or incest.

( ) The abortion is medically necessary as the 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 place the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION:

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

( ) Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.

( ) Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.

( ) Medical records documenting the life saving nature of the abortion.

( ) Other (Please Specify): _____

PATIENT ADDRESS:

_____
_____
_____

PHYSICIAN PERFORMING ABORTION:

SIGNATURE: _____
PHY. NAME: _____
PHY. SS#: __ __ __-__ __-__ __ __ __
PHY. ADD.: _____
_____
_____
_____

THIS FORM MAY BE DUPLICATED

CERTIFICADO DE NECESIDAD DE ABORTO

FECHA DEL SERVICIO: _____1_____

Basado en mi opinión profesional, certifico que un aborto es médicamente necesario en el caso de:

Nombre Completo del Paciente: _____**2**_____

Número de Seguro Social del Paciente: __ __ __ - __**3**__ - __ __ __ __

Por la siguiente razón:

(MARQUE UNA) **4**

( ) Hay suficiente evidencia para creer que el embarazo es el resultado de violación o incesto.

( ) El aborto es médicamente necesario ya que la mujer sufre de un desorden físico, daño físico o enfermedad física, incluyendo una condición que pone en peligro su vida causada o desarrollada por el embarazo mismo que pondría a la mujer en peligro de muerte al menos que el aborto se efectué.

DOCUMENTACION DE APOYO: **5**

(POR FAVOR MARQUE TODOS LOS QUE APLICAN Y ANEXE LOS DOCUMENTOS)

( ) Documentación de una agencia que ejecute la ley indicando que el paciente a hecho una denuncia creíble como una victima de violación o incesto.

( ) Documentación de una agencia de salud social, El Departamento de Servicios Humanos (DHS) o una agencia de concejeria (como el Centro de Crisis para Mujeres Violadas) indicando que el paciente hizo una denuncia creíble como una victima de violación o incesto.

( ) Historial médico que documente la razón del aborto como una de salvación de la vida de la mujer.

( ) Otro (Favor de especificar): _____

DIRECCION DEL PACIENTE: **CIRUJANO QUE HARA EL ABORTO:**

_____**6**_____
_____
_____

FIRMA: _____**7**_____
NOMBRE DEL DR.: _____**8**_____
SS# DEL DR.: __ __ __**-**__ __**-**__ __ __ __

DIRECCION DEL DR:

_____

ATTACHMENT VII - INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

Always Complete This Section

1. Enrollee Name: Enrollee's Name can be typed or handwritten. Must be completed.

2. TennCare ID No.: Enrollee's TennCare Number can be typed or handwritten. Must be completed.

3. Physician's Name: Physician's Name can be typed or handwritten. Must be completed.

4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete This Section For Enrollee Who Acknowledges Receipt Prior To Hysterectomy

5. Witness Signature Date: Witness must sign his/her name an date simultaneously in his/her own handwriting prior to surgery.

6. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery. (If the patient cannot sign her name she can make her mark "X" in patient's signature blank if there is a witness. The witness must sign down below his/her name and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting. The witness should write witness beside their name.

If Section A is completed, STOP HERE.

Section B: Complete This Section When Any Of The Exceptions Listed Below Is Applicable

7. Retroactive Eligible Enrollee Only: This box is checked only if the enrollee was approved retroactively. A copy of the TennCare card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.

8. This box is checked if the patient was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.

9. This box is checked if the patient had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.

10. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

Section C: Complete This Section For Mentally – Incompetent Enrollee

11. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.

12. Patient Representative Signature/Date: Patient representative must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.

13. Reason For Hysterectomy: Describe the reason for the hysterectomy. This may be typed or handwritten.

14. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting after surgery.

MEDICAID - TITLE XIX
ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

➔ALWAYS COMPLETE THIS SECTION🡐

Recipient Name _____ Medicaid ID No. _____

Physician's Name _____ Date of Hysterectomy _____

➔COMPLETE ONLY ONE OF REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION🡐

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

WITNESS' SIGNATURE DATE PATIENT'S SIGNATURE DATE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient listed below:

CHECK ONE

1 ☐ I informed her that this operation would make her permanently incapable of reproducing. (**This certification for retroactively eligible recipient only** - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made)

2 ☐ She was already sterile due to _____

CAUSE OF STERILITY

3 ☐ She had a hysterectomy performed because of a life-threatening situation due to _____

DESCRIBE EMERGENCY SITUATION

and the information concerning sterility could not be given prior to the hysterectomy.

PHYSICIAN'S SIGNATURE DATE

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT RECIPIENT ONLY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

WITNESS' SIGNATURE DATE PATIENT REPRESENTATIVE SIGNATURE DATE

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above recipient was medically necessary due to _____

REASON FOR HYSTERECTOMY

and was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her I counseled her representative, orally and in writing, that the hysterectomy would render that individual permanently incapable of reproducing; and, the individual's representative has signed a written acknowledgment of receipt of the foregoing information.

PHYSICIAN'S SIGNATURE DATE

Attach a copy to claim form when submitting for payment. Provide copies for patient and for your files. ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.

THIS FORM MAY BE REPRODUCED LOCALLY

MEDICAID – TÍTULO XIX
ACUSE DE RECIBO DE INFORMACIÓN SOBRE HISTERECTOMÍA

➔SIEMPRE DEBE LLENARSE ESTA SECCIÓN🡐

Nombre de la receptora _____ Número de ID de Medicaid _____

Nombre del Médico _____ Fecha de la histerectomía _____

➔SÓLO LLENE UNA DE LAS SECCIONES SIGUIENTES LLENE TODOS LOS ESPACIOS DE ESA SECCIÓN🡐

SECCIÓN A: LLENE ESTA SECCIÓN EN EL CASO DE QUE LA RECEPTORA RECONOZCA RECEPCIÓN PREVIA A LA HISTERECTOMÍA

Reconozco haber recibido información, tanto oral como escrita, previamente a la operación de histerectomía, en la cual se me ha indicado que, al ser llevada a cabo la histerectomía quedará incapacitada de manera permanente para procrear.

FIRMA DEL TESTIGO FECHA FIRMA DEL PACIENTE FECHA

SECCIÓN B: LLENE ESTA SECCIÓN CUANDO APLIQUE CUALQUIERA DE LAS EXCEPCIONES SIGUIENTES

Certifico que antes llevé a cabo el procedimiento de histerectomía sobre la receptora que se indica abajo:

MARQUE UNO

1 ☐ Le informé que esta operación la dejaría incapacitada de manera permanente para procrear. **(Esta certificación es sólo para receptora con derecho retroactivo** – antes de que pueda hacerse el reembolso, este formulario debe ser acompañado de la tarjeta de Medicaid que cubre la fecha de la histerectomía, o de copia del aviso de aprobación retroactiva.)

2 ☐ Ya era estéril debido a _____

CAUSA DE LA ESTERILIDAD

3 ☐ Se le practicó la histerectomía debido a una situación que ponía en peligro su vida, la cual fue causada por _____

DESCRIBA LA SITUACIÓN DE EMERGENCIA

por lo que no pudo proporcionarse la información acerca de la esterilidad antes de la histerectomía.

FIRMA DEL MÉDICO FECHA

SECCIÓN C: LLENE ESTA SECCIÓN SÓLO EN CASO DE QUE EL RECEPTOR SEA INCOMPETENTE MENTALMENTE

Reconozco haber recibido información, tanto oral como escrita, previamente a la operación de histerectomía que se va a llevar a cabo, indicando que al ser practicada la histerectomía a la receptora nombrada arriba, ella quedará incapacitada de manera permanente para procrear.

FIRMA DEL TESTIGO FECHA FIRMA DEL REPRESENTANTE DE LA PACIENTE FECHA

DECLARACIÓN DEL MÉDICO

Afirmo que la histerectomía que practiqué a la receptora antes mencionada fue necesaria desde el punto de vista médico debido a _____

RAZÓN DE LA HISTERECTOMÍA

y que no fue hecha con fines de esterilización, y que, a mi entender, la persona a la que se le practicó la histerectomía es mentalmente incompetente. Antes de practicar la histerectomía, informé a su representante, tanto de manera oral como escrita, que la histerectomía la dejaría incapacitada de manera permanente para procrear, y que el representante de la persona ha firmado un acuse de recibo por escrito de la información precedente.

FIRMA DEL MÉDICO FECHA

Adjunte una copia al formulario de reclamación cuando envíe el reclamo para su pago. Provea copias para el paciente y para sus archivos. SE PODRÍA SOLICITAR DOCUMENTACIÓN ADICIONAL ANTES DE EFECTUAR EL PAGO.

ESTE FORMULARIO PUEDE SER REPRODUCIDO LOCALMENTE

ATTACHMENT VIII - EPSDT SCREENING GUIDELINES

Recommendations of the EPSDT Screening Guidelines Committee

April, 2004

Developmental/ Behavioral Surveillance and Screening

Under Federal EPSDT rules, screening visits consist of a comprehensive health and developmental history, an unclothed physical exam, vision and hearing screenings , appropriate immunizations, laboratory tests, and health education. The purpose of these visits is to identify physical, mental, or developmental problems and risks as early as possible and to link children to needed diagnostic and treatment services. To comply with these rules and provide the highest quality of care, surveillance and screening procedures should be incorporated into the ongoing health care of the child and family as part of the provision of the medical home, as defined by the AAP (RE0062 - Developmental Surveillance and Screening of Infants and Young Children).

AAP Periodicity Guidelines (American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care) call for a developmental/behavioral assessment by history and appropriate physical examination at each visit interval. If findings identify concerns, specific objective developmental testing is needed. Developmental surveillance and developmental screening are the recommended methods for early detection of problems.

Developmental surveillance has been defined as "a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children during the provision of health care. The components of developmental surveillance include eliciting and attending to parental concerns, obtaining a relevant developmental history, making accurate and informative observations of children, and sharing opinions and concerns with other relevant professionals." Pediatricians and other health care providers often use age-appropriate developmental checklists to record milestones during preventive care visits as part of developmental surveillance. Developmental screening is a brief procedure, using a standardized tool, to determine whether a child requires further and more comprehensive evaluation.

All infants and young children should be assessed for developmental delays. School-age children and adolescents should receive additional evaluation for emotional/behavioral problems. The use of standardized screening instruments improve the accuracy of developmental assessments, and such tools exist that are both efficient and effective in the pediatric office and other settings such as primary health and public health centers. Tools listed below are

recommended tools and are listed by the focus of the tool and the target age range. Providers need to develop a strategy to provide periodic assessments in the context of ongoing office based primary care. It is recognized that practice setting will influence the type and frequency of assessments provided.

Practices should maintain and update knowledge of developmental issues, risk factors, screening techniques, and community resources for consultation, referral, and intervention. This should include acquiring skills in the administration and interpretation of reliable and valid developmental screening techniques appropriate for the population served.

Besides developmental/emotional/behavioral surveillance and screening, the listing includes a specialized screen for maternal post-partum depression. Assessment for this condition should be made in the first weeks after birth, and appropriate referral initiated as needed.

The listing also includes specific screens for autistic spectrum disorders. Early detection and referral for early intervention has been shown to improve long term outcomes in this group of disorders In addition, the prevalence of these disorders continue to increase.

Documentation of developmental/emotional/behavioral surveillance and screening should include a description of the method used, findings, and referral or treatment plans.

Developmental/Behavioral Screening Tools/Tests and Documentation Guidelines

Documentation Guidelines

Documentation should include a description of the developmental behavioral screening method. The following items should be documented in the medical record when developmental \ behavioral screening is done during an EPSDT encounter:.

- Any parental concerns about the child's development / behavior.
- A review of major age appropriate areas of development / behavior (e.g. motor, language, social, adaptive).
- An overall assessment of development / behavior for age (e.g. normal, abnormal, needs further evaluation).
- A plan for referral and /or further evaluation when indicated.

When validated developmental screening tests are performed in addition to the preventive medicine service or other services providers can report CPT code 96110 in addition to the Preventive Medicine Service. Examples listed in CPT include the Denver II and the Early Language Milestones Survey. This service is reported in addition to Preventive Medicine and other evaluation and management or screening services (hearing, vision, and laboratory) performed during the same visit. Informal developmental checklists are considered part of the history of the preventive medicine visit, and not reported and billed separately.

Developmental Screening Instruments

The following are list includes examples of developmental/behavioral screening tests approved by the EPSDT Screening Guidelines Committee for use in the EPSDT program. They have been approved and validated and used nationally. Providers who use alternative instruments should make a selection based on a similar standard of practice. These guidelines are subject to update and revision as needed.

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
Parental Post-Partum Depression	6 – 8 Weeks post-natal	***Edinburg Postnatal Depression Scale (EPDS)*** JL Cox, JM Holden, R Sagovsky, from British Journal of Psychiatry, June 1987, Vol. 150. User may reproduce the scale without further permission providing they respect the copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.	6 – 8 Weeks postnatal	Developed to assist primary care health professionals to detect mothers suffering from postnatal depression. Scale consists of ten items and indicates how the mother has been feeling during the previous week; it may be usefully repeated after two weeks.	Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptoms. Items marked with an asterisk are reversed scores. The total score is calculated by adding together the scores for each of the ten items.	Source article indicates that with mothers, who scored above threshold, 92.3% were likely to be suffering from a depressive illness of varying severity.	Less than five minutes
General Development (Including social language, motor, cognitive, self-help)	Birth till age nine. Generally developmental screens are indicated for older children (school age and above) only if it is suspected that a developmental problems has not been previously detected and/or diagnosed. Children beginning school and in early primary grades	**Ages & Stages (ASQ)** (Formerly Infant Monitoring System) Paul H. Brookes, Publishers PO Box 10624 Baltimore, Maryland 21285. (1.800.638.3775); www.brookespublishing.com (Initial cost of $190 for complete system [other purchase options such as questionnaire only, available]; also available on CD-ROM; but questionnaires, once purchased are reproducible and may be	0 to 60 months	Covers 19 different age intervals. Each questionnaire contains 30 developmental items written in simple, straightforward language, with reading levels ranging from fourth through sixth grade. Each of the 19 questionnaires (for a specific age interval) covers the following areas: communication, gross and fine motor, problem solving and personal-social. Clear drawings and simple	Single pass/fail score	Sensitivity ranges from 70% to 90% at all ages except the 4-month level. Specificity ranges from 76% to 91%	Scoring takes about 7 minutes; questionnaire can be completed in 10-20 minutes.

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
	may benefit from developmental screen as a means to detect learning problems	copied after initial purchase)		directions help parents indicate children's skills. There are separate copyable forms of 10 to 15 items for each age range (tied to health supervision visit schedule). Can be used in mass mail-outs for child-find programs. Available in English, French, Spanish and Korean.			
		Brigance Screens. Billerica, MA: Curriculum Associates, Inc. (1985), 153 Rangeway Road, N. Billerica, MA 01862 (1.800.225.0248)	21 to 90 months	Seven separate forms, one for each 12 month range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observations. Acceptable as a screen, but due to extensive direct testing, used more often as a secondary screen	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to develop-mental and academic problems was 70% to 82%	10 minutes (direct testing only)
		Child Development Inventories (formerly Minnesota Child Development Inventories (1992). Child Development Review Behavior Science	Birth to 72 months	60 yes/no descriptions with separate forms for 0-18 months (***Infant Development Inventory*** {IDI] 18-36 months. (***Early Child Development Inventory***	A single cut-off tied to 1.5 Standard Deviations below the mean	Sensitivity was 75% or greater across studies and specificity was 70%	About 10 minutes (if interview needed)

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
		Systems, Inc. Box 19512 Mpls., MN 55419-9998 612-850-8700 fax 360-351-1374 Childdevelopmentreview.com Heidi@childdevrev.com		{ECDI}) and 3 years to Kindergarten (***Preschool Development Inventory*** {PDI})IDI includes a developmental milestones chart for the first 21 months of life span, across five domains (social, self-help, gross and fine motor and language). Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation			
		Child Development Review Child Development Review Behavior Science Systems, Inc. Box 19512 Mpls., MN 55419-9998 612-850-8700 fax 360-351-1374 Childdevelopmentreview.com Heidi@childdevrev.com Manual, $11, pad of 25 parent questionnaires backed with First Five	18 months to kindergarten	6 questions for parents and a 26 item possible behavioral and emotional problems. The chart that is included can be used as a parent interview guide or to observe and record development in five areas: social self-help, gross and fine motor, and language. Development and age norms are based on research with the **Child Development Inventories** (see above) problems list, backed with a First Five Years	Parents' responses to the six questions and problem checklist are classified as indicating 1) No problem, 2) a Possible Problem, or 3) Possible Major Problem. The Child Development chart results are compared to age norms, and classifies as	Sensitivity 68% or greater. Specificity 88%	5 minutes (if interview needed)

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
		Years Child Development Chart, $11.		Child Development Chart. The chart can be used for observation, as a parent interview guide, or as parent education tool. The CDR helps determine whether a child's development is "normal," borderline," or "delayed" in five developmental areas; energy, motor symptoms, language symptoms, behavioral and emotional problems. The chart that is included can be used as a parent interview guide or to observe and record development in five areas: social self-help, gross and fine motor, and language.	"typical: for age in all areas, or as "borderline" or "delayed" in one or more areas of development. Guidelines for identifying indicators of need for follow-up are described in the manual		
		Denver-II Denver Developmental Materials, Inc. P.O. Box 371075 Denver, CO 80237-5075 (303) 355-4729** 1-800-419-4729 Fax* (303) 355-5622 www.denverii.com/DenverII.html Cost: Test kit, $50; Training Manual, $25;	Birth to 6 Years	Combination of directly elicited and interviews, tapping language, personal-social gross and fine motor, but not academic or pre-academic skills. Available in English and Spanish	Pass/fail Questionable/ un-questionable	Sensitivity 80% and specificity 40% or sensitivity 40% and specificity 80% depending on how the questionable score is handled.	15 minutes for younger children, 26 minutes for older children (combination of direct and interview items)

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
		Test forms (pkg of 100), $24 for English; $28 for Spanish.					
		Parents' Evaluations of Developmental Status (PEDS) (1997) Ellsworth & Vandemeer Press, Ltd. P.O. Box 68164, Nashville, TN 37206 Phone: 615-226-4460; fax: 615-227-0411 http://www.pedstest.com ($38.99)	Birth to 9 years	10 questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Available in English & Spanish. Written at the 5th grade level. Normed in teaching hospitals and private practice.	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	Sensitivity ranged from 74% to 79% and specificity ranged from 70% to 80%.	About 2 minutes (if interview needed)
Autism & Pervasive Development Disorders (PDD)	12 months thru 36 months of age, depending upon screening tool used, and age of child at time of screen. Child should be screened once during 12 to 36 month age interval.						
		Modified Checklist for Autism in Toddlers (M-CHAT). DL Robins, D. Fein, ML Baron and JA Green. Modified Checklist for	18 months of age	Consists of 23 yes/no questions using the original nine from the CHAT(see above). Goals of the M-CHAT are to improve the	Child fails the checklist when 2 or more critical items or any three items are failed.	Authors indicate that research is pending on sensitivity and specificity	About five minutes

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
		Autism in Toddlers (M-CHAT). Journal of Autism and developmental Disorders.		sensitivity of the CHAT and position it better for an American audience.	Since it is a screen, a "failing" score is viewed as a need for further evaluation as not all children who have a failing score meet the criteria for a diagnosis on the autism spectrum		
Behavioral/ Emotional	4 through 20 Years of Age	**Eyeberg Child Behavior Inventory**	2 ½ to 11 year (best used to age 4)	A total of 36 short statements of common behavior problems. A score of more than 16 suggest referral for behavioral interventions. Fewer than 16 enable the measure to function as a problem list for planning in-office counseling and selecting handouts.	Single refer/non-refer score for externalizing problems (e.g. conduct, attention, aggression)	Sensitivity 80%; specificity 86%	About 7 minutes
		PEDS	Note: The **PEDS** can also be used to screen possible behavioral problems up to age 9	See description above under **General Development**			
		Pediatric Symptom Checklist (PSC) Jellinek	6 to 18; with modification	35 short statements of problem behaviors to	***Single refer/non-refer***	Sensitivity ranged from	About 7 minutes (if

*Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy*	Time Frame
		MS, Murphy, JM, Robinson, J et al. Pediatric Symptom Checklist: Screening school age children for psychosocial dysfunction. Journal of Pediatrics, 1998; 112-201-209 (the test is included in the article and in the PEDS manual); can be downloaded at: www.state.tn.us/tenncare/provider.html	of items (see article, can be adapted for ages 4 & 5)	which parents respond with "never," "sometimes," or "often." The PSC screens for academic and emotional/behavioral difficulties.	***score***	80% to 95%. Specificity in all but one study was 70% to 100%.	interview needed)
		PSC-17 Gardner W. *et. al.* The PSC-17: A brief symptom checklist psychosocial problem subscales: A report from PROS and ADSPN. *Ambulatory Child Health.* 1999; 5:225-236. Can be downloaded at: www.pedstest.com/links/files/psc.pdf	4 to 18	17 short statements of problem behaviors to which parents respond with "never," "sometimes," or "often." The PSC-17 screens for academic and emotional/behavioral difficulties, and includes three subscales (Aggression, Attention and Depression.)	Cut-off scores of 7 or above for aggression and attention subscales; 5 or above for depression subscale; or 15 or above for the entire 17 item screen.	Good sensitivities (.77 - .87) and specificities (.68 - .80) at the optimal cutoff points were reported in the Gardner et. al. study.	Less than 7 minutes.

- Accuracy is defined as both sensitivity and specificity
- Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test.
- Specificity = percentage of children without disabilities identifies as probably normal by a screening test

* Focus of Screen:

Includes the range of problems screened (i.e. general developmental, autism and pervasive developmental disorders, post-natal depression, behavioral)

Targeted Age Range:
Indicates within what age ranges these problems are screened.

Description:
Provides information on alternatives ways (if available) to administer measures (e.g., waiting rooms).

Scoring:
Shows general information regarding pass/fail criteria and cutoff scores

Accuracy:
Shows the percentage of patients with and without problems identified correctly.

Time Frame:
Shows the cost of professional time needed to administer and score each measure. For parent report measures, administration time reflects not only scoring of the results, but also each test's reading level and the percentage of TennCare patients with less than a high school education (who may or may not be able to complete measures due to literacy problems and will thus need office staff to read the screen to them.)

References

AAP Periodicity Guidelines (American Academy of Pediatrics recommendations for Preventive Health Care) (RE9939)
http://www.aap.org/policy/periodicity.pdf

Developmental Surveillance and Screening of Infants and Young Children (RE0062)
http://www.aap.org/advocacy/archives/julyscreen.htm

Recommendations of the EPSDT Screening Guidelines Committee

April, 2004

HEARING SCREENINGS:

- Hearing screenings performed as recommended by AAP periodicity guidelines and using acceptable methods will meet requirements for EPSDT screens.
- The goal of universal newborn hearing screening (UNHS) is to have all infants have access to hearing screening using a physiologic measure. Newborns who receive routine care have access to hearing screening during their hospital admission. Newborns in alternative birthing facilities, including home births, have access to and are referred for screening before 1 month of age. All newborns or infants who require neonatal intensive care receive hearing screening before discharge from the hospital. The components constitute UNHS.
- The goal of newborn screening is to also have all infants screened prior to discharge from hospital after birth or prior to one month; prior to 3 months refer all infants that did not pass the screen for diagnostic assessment (medical and audiological, if indicated); implement early intervention services prior to six months.
- Infants who did not pass screening should be referred for diagnostic assessment of hearing. A prompt re-screening might be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well—child visit.
- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include physiologic audiological screening such as auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Acceptable methods of objective hearing screening include: physiologic audiological screening for newborns, such as ABR or OAE , conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.
- If there are parental concerns about hearing, at any age, then an objective screening test or diagnostic should be performed.

- Children newly entering the program (i.e. new to a practice, without medical documentation) should be brought up to date on all screening criteria.
- Physiological screening may be acceptable for older children and children who are not cooperative with conventional means (i.e. hand-held audiometry, conventional audiometry).
- Interperiodic screenings may also be conducted between recommended testing intervals.
- Progressive hearing loss may be associated with different risk factors. Please refer to references after guidelines for articles, resources that enumerate the risk indicators for progressive or late –onset hearing loss.

	Recommendations for Hearing Screening	
	Subjective	*Objective*
Newborn	• Parental concern • Family history	• ABR or OAE, if not performed in hospital
By 1 month	• Parental concern	• Ear exam • If infant does not pass the hearing screen in the hospital , provide a medical evaluation and re-screen by one month or perform diagnostic testing as soon as possible prior to three months of age.

2 months	• Parental concern • Family history (unless previously recorded) • Response to voice and noise - parent report	• Ear exam • Confirmatory pediatric audiologic diagnostic evaluation of abnormal screening result should be completed prior to 3 months of age.
4 months	• Parental concern • Recognizes parent's voice - parent report • Family history (unless previously recorded)	• Ear exam • Infants with a confirmed hearing loss should begin audiological intervention and other early intervention services prior to six months.
6 months	• Parental concern • Turns to sounds - parental report • Family history (unless previously recorded)	• Ear exam • Infants with a confirmed hearing loss should begin audiological intervention and other early intervention services prior to six months.
9 months	• Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam

12 months	• Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam
15 months	• Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam
18 months	• Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam
24 months	• Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam
3 years	• Parental concern	• Ear exam • Hearing screen if child is cooperative.

4 years	• Parental concern	• Ear exam • Hearing screen (if not done at 3 years)
5 years	• Parental concern	• Ear exam • Hearing screen
6 years	• Parental concern	• Ear exam • Hearing screen
7 years	• Parental and patient concern	• Ear exam • Hearing screen (if not done at 6 years)
8 years	• Parental and patient concern	• Ear exam • Hearing screen
9 years	• Parental and patient concern	• Ear exam • Hearing screen (if not done at 8 years)
10 years	• Parental and patient concern.	• Ear exam • Hearing screen
11 years	• Parental and patient concern.	• Ear exam • Hearing screen (if not done at 10 years)
12 years	• Parental and patient concern.	• Ear exam • Hearing screen
13 years	• Parental and	• Ear exam

	patient concern	• Hearing screen (if not done at 12 years) •
14 years	• Parental and patient concern.	• Ear exam • Hearing screen (if not done at 12 or 13 years)
15 years	• Parental and patient concern.	• Ear exam • Hearing screen
16 years	• Parental and patient concern.	• Ear exam • Hearing screen (if not done at 15 years)
17 years	• Parental and patient concern.	• Ear exam • Hearing screen (if not done at 15, or 16 years)
18 years	• Parental and patient concern.	• Ear exam • Hearing screen
19 years	• Parental and patient concern.	• Ear exam
20 years	• Parental and patient concern.	• Ear exam

References

Universal Newborn Hearing Screening, Diagnosis and Intervention Guidelines for Pediatric Medical Home Providers (Flow Chart) – AAP January 2003

Joint Committee on Infant Hearing Detection and intervention Programs: Year 2000 Position Statement.

www.medicalhomeinfo.org/screening/hearing.html

Recommendations of the EPSDT Screening Guidelines Committee

April, 2004

Vision Screenings

- Screening of visual problems is important during critical age interval to detect several potential problems. These include:

    1) Screening of extremely prematurely born infants for Retinopathy of Prematurity (ROP), especially those who have received oxygen therapy.

    2) Screening for congenital cataracts and retinoblastoma at birth and through age 18 months of age.

    3) Screening as early as possible time for amblyopia and refractive errors. Please refer to the chart (below) for screening intervals

- Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 M, Random Dot E Stereotest at 40 cm (630 secs of arc). Photoscreening is not a substitute for accurate visual acuity measurement but can provide significant information about the presence of sight-threatening conditions such as strabismus, anisometropia, high hyperopia, media opacities (cataract),.

- Photoscreening results are accurate only with proper interpretation.

- Simultaneous Red Reflex Test (Bruckner Test) can detect amblyogenic conditions, such as unequal refractive errors (unilateral high myopia, hyperopia, or astigmatism), but require skilled examiners.

- Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling E, HOTV, Picture Tests, Allen Figures, LH Symbols (LEA Symbols).

- Assessments of visual acuity should be performed with an eye patch or eye taped shut, or similar procedure, in order to ensure results,

- Eye exams should entail an anterior segment inspection. The AAP/AAO Policy Statement in **Pediatrics,** April, 2003, should serve as the standard.

- If there are parental concern about vision , at any age, then an objective screening test or diagnostic should be performed

- Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes his initial screening result is likely to be a false positive. Re-screening should be done

within 2-4 weeks rather than waiting until the next scheduled well child visit.

- Interperiodic screenings may also be conducted between recommended testing intervals.

	Recommendations for Vision Screening	
	Subjective	*Objective*
High Risk Prematurely Born Children; assessment to be performed by 33 weeks of gestational age or 6 weeks post-natal (which ever comes later)	N/A	• If gestation is less than 28 weeks or weighing less than 1500 grams, child should be referred to a Pediatric Ophthalmologist for screening for Retinopathy of Prematurity (ROP) such that the first retina exam can occur by 33 weeks of gestational age or six weeks, post-natal .
Newborn		• Eye exam: red reflex, corneal inspection. Eye exam should include the following elements: external inspection, examination of anterior segment, & red reflex

By 1 month	• Parental concern about vision	• Eye exam: red reflex, corneal inspection Eye exam should include the following elements: external inspection, examination of anterior segment, & red reflex
2 months	• Parental concern about vision	• Eye exam: red reflex, corneal inspection Eye exam should include the following elements: external inspection, ocular motility, examination of pupils, & red reflex • Fixes on face, follows with eyes
4 months	• Parental concern about vision	• Eye exam: red reflex Eye exam should include the following elements: external inspection, ocular motility, examination of pupils, & red reflex • Fixes and follows each eye

	Subjective	*Objective*
6 months	• Parental concern about vision	• Eye exam: red reflex Eye exam should include the following elements: external inspection, ocular alignment and motility, examination of pupils, & red

		reflex • Fixes and follows each eye
9 months	• Parental concern about vision	• Eye exam: red reflex Eye exam should include the following elements: external inspection, ocular motility and alignment, examination of pupils, & red reflex • Fixes and follows each eye
12 months	• Parental concern about vision	• Eye exam • Fixes and follows each eye
15 months	• Parental concern about vision • Can see small objects	• Eye exam
	Recommendations for Vision Screening	
	Subjective	*Objective*
18 months	• Parental concern about vision • Can see small objects	• Eye exam
24 months	• Parental concern about vision	• Eye exam. • Ocular alignment, beginning at

	• Can see small objects	age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval.
3 years	• Parental concern about vision • Can see small objects	• Eye exam • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval. • Visual acuity (should be obtained as early as cooperation and valid results can be obtained.)
4 years	• Parental concern about vision	• Eye exam. • Visual acuity if not done at 3 years. • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval.
5 years	• Parental concern about vision	• Eye exam • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed

		at a prior age interval. • Visual acuity (if not done at 3 or 4 years)
6 years	• Parental concern about vision	• Eye exam • Visual acuity • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval.
7 years	• Parental and patient concern about vision	• Eye exam • Visual acuity testing (if not done at 6 years)
8 years	• Parental and patient concern about vision	• Eye exam • Visual acuity testing
9 years	• Parental and patient concern about vision	• Eye exam • Visual acuity testing if not done at 8 years.
10 years	• Parental and patient concern about vision	• Eye exam. • Visual acuity

11 years	• Parental and patient concern about vision	• Eye exam. • Visual acuity (if not done at 10 years)
12 years	• Parental and patient concern about vision	• Eye exam • Visual acuity
13 years	• Parental and patient concern about vision	• Eye exam. • Visual acuity if not done at age 12.
14 years	• Parental and patient concern about vision	• Eye exam • Visual acuity testing (if not done at 12 or 13)
15 years	• Parental and patient concern about vision	• Eye exam • Visual acuity testing
16 years	• Parental and patient concern about vision	• Eye exam • Visual acuity testing (if not done at 15 years)/should be done for purpose of ensuring drivers license
17 years	• Parental and patient concern about vision	• Eye exam • Visual acuity (if not done at 15

		or 16 years) •
18 years	• Parental and patient concern about vision	• Eye exam. • Visual acuity
19 years	• Parental and patient concern about vision	• Eye exam • Visual acuity if not done at 18 years.
20 years	• Parental and patient concern about vision	• Eye exam • Visual acuity if not done at 18 or 19 years.

References

Eye Examination in Infants, Children, and Young Adults by Pediatricians, Policy Statement, American Academy of Pediatrics, American Association of Certified Orthoptists, American Association for Pediatric Ophthalmology and Strabismus, American Academy of Ophthalmology, PEDIATRICS, Vol. 111, No. 4, April 2003.

ATTACHMENT IX - FORMS FOR REPORTING FRAUD AND ABUSE

ATTACHMENT IX

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 X - CAPITATION RATES

ATTACHMENT X.A
CAPITATION RATES EFFECTIVE JULY 1, 2001

For the purpose of capitation rates presented below, dual enrollees are TennCare eligibles who have Medicare eligibility. The disabled rate is only for those disabled individuals who are Medicaid eligible. The capitation rates effective July 1, 2001 are:

[INSERT JULY 1, 2001 INDIVIDUAL RATE CHARTS]

ATTACHMENT X.B
RETROACTIVE CAPITATION RATES

The capitation rate for retroactive periods of eligibility shall be as follows:

1. For retroactive periods of enrollment from July 1, 2000 through June 30, 2001:

   For the purpose of capitation rates presented below, dual enrollees are TennCare eligibles who have Medicare eligibility. The disabled rate is only for those disabled individuals who are Medicaid eligible. The following shall be applicable to calculating the capitation rate:

   [INSERT July 1, 2000 rates for Existing MCOs, include a NOTE: Rates on Following Page INSERT July 1, 2001 rates for New MCOs]

RETRO RATES FOR EXISTING PLANS GO HERE

2. For retroactive periods of enrollment from July 1, 1993 through June 30, 2000:

Enrollee Category	**Effective July 1, 1993 – June 30, 1994**[^]	**Effective July 1, 1994 – December 31, 1994**[^]	**Effective January 1, 1995 – June 30, 1995**[^]	**Effective July 1, 1995 – June 30, 1996**	**Effective July 1, 1996– June 30, 1997**	**Effective July 1, 1997 – June 30, 1998**	**Effective July 1, 1998 – June 30, 1999**	**Effective July 1, 1999 – June 30, 2000**
TennCare Eligibles								
Under Age 1	$115.55	$125.60	$118.71	$122.73	$ 127.64	$137.17	$144.03	$157.29
Ages 1 to 13	$40.25	$43.75	$41.35	$37.84	$ 39.35	$39.61	$41.59	$56.80
Ages 14 to 44 (male)	$73.83	$80.23	$75.84	$75.68	78.71	$78.71	$82.65	$97.07
Ages 14 to 44 (female)	$121.98	$132.58	$125.31	$129.97	$ 135.17	$136.45	$143.27	$156.54
Ages 45 to 64	$128.18	$139.32	$131.68	$136.95	$ 142.43	$144.35	$151.57	$164.68
Ages 65 and over	$53.46	$58.11	$54.92	$52.72	$ 54.83	$162.78	$170.92	$183.66
Aid to the blind and disabled	$251.19	$273.02	$258.05	$275.61	$ 286.63	$286.63	$300.96	$311.23
TennCare Dual Eligibles/Medicaid/Medicare Duals	$64.42	$70.01	$66.18	$65.09	$ 67.69	$87.86	$94.01	$108.25

[^] Rates include payment for behavioral health services.

ATTACHMENT X.C
RETROACTIVE COST-SHARING SCHEDULES

Enrollee cost-sharing responsibilities for retroactive eligibility periods shall be determined according to the following schedule:

TennCare Deductibles and Out-Of-Pocket Expenditures

Percentage of Poverty	**0% - 100%**	**101% - 199%**	**200% - Over**
Less than 200% of Poverty			
Annual Deductible (Individual)	$0	$250	$250
Annual Deductible (Family)	$0	$500	$500
Annual Deductible (Children)	$0	$0	**Same as Adults**
Out-Of-Pocket Expenses (Individual)	$0	$1,000	$1,000
Out-Of-Pocket Expenses (Family)	$0	$2,000	$2,000
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	**0 - 650**	**651 - 1,289**	**1,290 - Over**
2	**0 - 871**	**872 - 1,725**	**1,726 - Over**
3	**0 - 1,092**	**1,093 - 2,163**	**2,164 - Over**
4	**0 - 1,312**	**1,313 - 2,599**	**2,600 - Over**
5	**0 - 1,532**	**1,533 - 3,035**	**3,036 - Over**
6	**0 - 1,753**	**1,754 - 3,473**	**3,474 - Over**
7	**0 - 1,974**	**1,975 - 3,909**	**3,910 - Over**
8	**0 - 2,194**	**2,195 - 4,345**	**4,346 - Over**
9	**0 - 2,415**	**2,416 - 4,783**	**4,784 - Over**
10*	**0 - 2,635**	**2,636 - 5,219**	**5,220 - Over**
***For each family member over 10, add per month**	**0 - 219**	**220 - 435**	**436 - Over**

ATTACHMENT X.C
RETROACTIVE COST-SHARING SCHEDULES

TennCare Co-Pay Sliding Scale

Percentage of Poverty	0% - 100%	101% - 119%	120% - 139%	140% - 169%	170% - 199%	200% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	0 - 650	651 - 773	774 - 902	903 - 1,096	1,097 - 1,289	1,290 - Over
2	0 - 871	872 - 1,035	1,036 - 1,207	1,208 - 1,466	1,467 - 1,725	1,726 - Over
3	0 - 1,092	1,093 - 1,297	1,298 - 1,514	1,515 - 1,838	1,839 - 2,163	2,164 - Over
4	0 - 1,312	1,313 - 1,559	1,560 - 1,819	1,820 - 2,209	2,210 - 2,599	2,600 - Over
5	0 - 1,532	1,533 - 1,821	1,822 - 2,124	2,125 - 2,580	2,581 - 3,035	3,036 - Over
6	0 - 1,753	1,754 - 2,083	2,084 - 2,431	2,432 - 2,952	2,953 - 3,473	3,474 - Over
7	0 - 1,974	1,975 - 2,345	2,346 - 2,736	2,737 - 3,323	3,324 - 3,909	3,910 - Over
8	0 - 2,194	2,195 - 2,607	2,608 - 3,041	3,042 - 3,693	3,694 - 4,345	4,346 - Over
9	0 - 2,415	2,416 - 2,869	2,870 - 3,348	3,349 - 4,065	4,066 - 4,783	4,784 - Over
10*	0 - 2,635	2,636 - 3,131	3,132 - 3,653	3,654 - 4,436	4,437 - 5,219	5,220 - Over
*For each family member over 10 add per month	0 - 219	220 - 261	262 - 304	305 - 370	371 - 435	436 - Over
Percentage of Payments for Adults	0%	2%	4%	6%	8%	10%
Percentage of Payments for Children	0%	2%	2%	2%	2%	10%

Special Fees

Service	Fee
Emergency Room Services (non-emergency room situations)	$25 Per Visit For Non-Medicaid Eligible Enrollees

ATTACHMENT X.D
ADMINISTRATIVE RATES

Table X.D.1 Stabilization Rates through June 30, 2005

Administrative Fees	July 2002 through September 2002	October 2002 through June 30, 2003	July 1, 2003 through June 30, 2005
Medicaid	$9.03	$8.67	$11.63
Disabled	$27.97	$27.78	$32.61
Uninsured	$9.70	$9.46	$12.24
Uninsurable (Medically Eligible)	$22.15	$22.06	$27.89
Duals	$1.55	$1.51	$2.32

Table X.D.2 Administrative Rates Effective July 1, 2005

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	$11.37
100,000 to 199,999 enrollees	$11.25
200,000 to 299,999 enrollees	$11.12
300,000 to 399,999 enrollees	$11.00
400,000 to 499,999 enrollees	$10.89
500,000 to 599,999 enrollees	$10.68
600,000 to 699,999 enrollees	$10.53
700,000 to 799,999 enrollees	$10.38
800,000 to 899.999 enrollees	$10.23
900,000 to 999,999 enrollees	$10.08
1,000,000 or more enrollees	$9.93

Table X.D.3 Administrative Rates Effective July 1, 2006

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	$11.57
100,000 to 199,999 enrollees	$11.45
200,000 to 299,999 enrollees	$11.32
300,000 to 399,999 enrollees	$11.20
400,000 to 499,999 enrollees	$11.09
500,000 to 599,999 enrollees	$10.88
600,000 to 699,999 enrollees	$10.73
700,000 to 799,999 enrollees	$10.58
800,000 to 899.999 enrollees	$10.43
900,000 to 999,999 enrollees	$10.28
1,000,000 or more enrollees	$10.13

The applicable administrative fee shall be determined based upon the total number of enrollees in the month preceding the month in which payment is made to the Contractor as determined by TENNCARE. The administrative fee specified shall be applicable to all enrollees upon attainment of an enrollment level. For example, if enrollment for the month of February is 250,000 enrollees, the administrative fee payment for the month of March shall be $11.12 per member per month for each enrollee assigned to the CONTRACTOR during the month of March.

ATTACHMENT XI - COST SHARING SCHEDULES

ATTACHMENT XI
COST-SHARING SCHEDULES

1. Out-of-Pocket Expenditures

The TENNCARE deductible for children, individuals and families shall be $0.00. The annual TENNCARE maximum out-of-pocket expenditures described below shall apply for both uninsured and uninsurable designations. Effective August 1, 2005 (unless otherwise directed by TENNCARE), there shall be no out-of pocket maximum amounts.

Poverty Level	**Individual Maximum Annual Out-of-Pocket**	**Family Maximum Annual Out-of-Pocket**
0%-100%	$0.00	$0.00
101% - 199%	$1,000.00	$2,000.00
200% and above	$2,000.00	$4,000.00

2. Copayments prior to January 1, 2003:

The following TENNCARE copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TENNCARE rule 1200-13-12-.05(1)(c):

Poverty Level	**Copayment Amounts**
0%-100%	$0.00
101% - 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 $5.00, Prescription or Refill $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 $10.00, Prescription or Refill $200.00, Inpatient Hospital Admission

3. **Copayment schedules effective January 1, 2003 shall be as follows:**

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) $5.00, Prescription or Refill $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) $10.00, Prescription or Refill $200.00, Inpatient Hospital Admission

4. **Pharmacy Copayment schedules effective August 1, 2005 (unless otherwise directed by TENNCARE) shall be as follows:**

Pharmacy Copays shall apply to all TennCare Standard enrollees as well as non-institutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. For dates of service on or after July 1, 2005, these pharmacy copayment amounts shall replace the pharmacy copay amounts specified in Item 3 above. All other copay amounts specified in Item 3 shall remain in effect for TennCare Standard enrollees.

Generic	$0
Brand Name	$3

Pharmacy Copayments do not apply to family planning services, pregnant women, enrollees in long term care institutions (including HCBS) or receiving Hospice care.

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

Changes in cost share responsibilities that are due to take effect August 1, 2005 may be postponed as a result of Waiver and/or Court negotiations. Changes should be implemented August 1, 2005 unless otherwise directed by TENNCARE.

ATTACHMENT XII - REPORTING REQUIREMENTS

The CONTRACTOR and TENNCARE are responsible for complying with all the reporting requirements established by the parties. Both parties are responsible for assuring the accuracy and completeness of all reports as well as the timely submission of each report. Both parties will agree to the appropriate reporting formats, instructions, submission timetables, and technical assistance as required.

ATTACHMENT XII, EXHIBIT A - REPORTING ENROLLEE INFORMATION/ REQUIRED DATA ELEMENTS

ATTACHMENT XII, EXHIBIT A
REQUIRED DATA ELEMENTS FOR REPORTING ENROLLEE INFORMATION

This report shall include, at a minimum, the following data elements:

1. Enrollee's name;

2. Enrollee's social security number;

3. Enrollee’s date of birth;

4. Enrollee’s sex;

5. Enrollee's previous address;

6 Enrollee's new address; or

To the extent possible, a statement or indicator that the enrollee’s new address is unknown due to mail being returned for insufficient address (e.g., undeliverable, no forwarding address, etc.) if the enrollee’s new address is unknown;

7. Date enrollee moved;

8. A statement or indicator whether the enrollee's new address is within the same community service area as the former address or is in a different community service area;

9. Identity of the new MCO plan, if known, if the enrollee has moved outside the former community service area and desires to change MCO plans;

10. The identity of the MCO providing notice; and

11. Other pertinent information which is known by the CONTRACTOR which may have an affect on an enrollee’s eligibility or cost sharing status.

ATTACHMENT XII, EXHIBIT B – ENROLLEE VERIFICATION REPORTING/REQUIRED DATA ELEMENTS

ATTACHMENT XII, EXHIBIT B
REQUIRED DATA ELEMENTS FOR ENROLLEE VERIFICATION REPORTING

In response to receipt of a file from TENNCARE that identifies individuals whom TENNCARE has not been successful at contacting to verify eligibility, the CONTRACTOR will provide a response file that will include, at a minimum, the following data elements:

1. Enrollee's social security number;

2. Enrollee's date of birth;

3. Enrollee's sex;

4. Enrollee's name; and

5. Enrollee's address.

ATTACHMENT XII, EXHIBIT C - PROVIDER ENROLLMENT REPORTING/REQUIRED DATA ELEMENTS

ATTACHMENT XII, EXHIBIT C
REQUIRED DATA ELEMENTS FOR PROVIDER ENROLLMENT REPORTING

This provider listing shall include, at a minimum, the following data elements:

1. Provider name;

2. Provider address, including the address of all service sites operated by the provider (a P.O. Box is not acceptable);

3. Tax/Employer I.D. number (EIN) or Provider social security;

4. Provider's race and/or national origin;

5. Provider Specialty 1and Specialty 2;

6. Provider license number and type of license (if applicable);

7. Tennessee Medicaid Provider I.D. Number for the individual provider being enrolled (Should correspond to the Provider Name) .;

8. Unique Individual MCC Provider I.D. Number (Should correspond to the Provider Name);

9. Medicare I.D. number, if applicable (Should correspond to the Provider Name);

10. Initial Credentialing Date;

11. Recredentialing Date (This date must reflect the actual date recredentialing completed);

12. Provider telephone number (including area code) for each provider service site (up to 6 phone numbers);

13. Provider's Drug Enforcement Agency (DEA) number (if applicable);

14. Begin date of participation and end date of participation (if applicable);

15. Contracted Provider versus Non-Contracted Provider Indicator (single case agreements are considered Non-Contracted Providers);

16. Indicate whether or not the following services are provided by the provider: Obstetrics, General Surgery, Pediatrics, or EPSDT;

17. Is the provider board certified;

18. The provider's service delivery county of practice; and

19. Indicate whether or not the provider's practice is limited to male or female patients;

20. Date disclosure form/attestation signed by provider;

For Dentists and Primary Care Providers (PCP) the following additional data elements are required:

21. Is the Dental / PCP's practice closed to new TennCare members as primary care patients;

For Primary Care Providers (PCPs only) the following additional data elements are required:

22. Does the PCP deliver babies;

23. Does the PCP provide prenatal care;

24. What is the youngest age each individual PCP will accept as a patient into the PCP's practice? (Age zero (00) equates to providing services to newborns);

25. What is the oldest age each individual PCP will accept as a patient into the PCP's practice? (Age 99 equates to Age 99 and older); and

26. How many members has the MCO assigned to each individual PCP for primary care service delivery?

ATTACHMENT XII, EXHIBIT D – ESSENTIAL HOSPITAL SERVICES CHART

ATTACHMENT XII, EXHIBIT D

Instructions for Completing the Essential Hospital Services Chart

This report is to be prepared based on the MCO's provider network for essential hospital services in each Grand Region in which the MCO has (or expects to have) TennCare enrollees.

- 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 enrollees in the Grand Region and the date that such total enrollment was established.

- The MCO should provide information on each Tertiary Care Facility with which that MCO has a contractual or out-of-network relationship for serving enrollees in the identified Grand Region. The MCO should use a separate row to report information on each such Tertiary Care Facility.

1. In the first column, "Tertiary Care Facility" indicate the complete name of the Tertiary Care 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: "CSA", indicate the name of the TennCare Community Service Area (CSA) in which this facility is located.

4. In the fourth through the tenth columns indicate the status of the MCO's relationship with the specific Tertiary Care Facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS and Center of Excellence for Children at Risk or in State Custody.

    - For example, if the MCO has an executed contract with the Tertiary Care Facility for Neonatal services, insert an "E" in the column labeled "Neonatal".

    - If an MCO does not have an executed contract with this Tertiary Care Facility for "Neonatal", but has another type of arrangement with this facility, the MCO should indicate the code that best describes its relationship with the facility (e.g. L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the MCO does not have an executed contract but is using as an out of network provider, the MCO should submit a brief description (one paragraph) of its relationship with the Tertiary Care Facility including a estimated timeline for executing a contract, if any.

    - If an MCO does not have any relationship for Neonatal services with the Tertiary Care Facility on this row, the MCO should leave the column labeled "Neonatal" blank.

ATTACHMENT XII, EXHIBIT D

ESSENTIAL HOSPITAL SERVICES

MCO Name:_____ **Grand Region: _____**

Number of MCO Enrollees:_____ **as of (date): _____**

Name of Tertiary Care Facility	City/Town	CSA	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Children at risk or in Custody COE	Comments

E = Executed Contract
L = Letter of Intent
R = On Referral Basis
N = In Contract Negotiations
O = Other Arrangement

ATTACHMENT XII, EXHIBIT E – LEFT BLANK INTENTIONALLY

ATTACHMENT XII, EXHIBIT F - REPORTING OTHER INSURANCE/REQUIRED DATA ELEMENTS

ATTACHMENT XII, EXHIBIT F
REQUIRED DATA ELEMENTS FOR REPORTING OTHER INSURANCE

This report shall include, at a minimum, the following data elements:

1. Enrollee's name;

2. Enrollee's social security number;

3. Enrollee’s date of birth;
4. Enrollee's group insurance number;

5. Enrollee's individual insurance number;

6. Policy limitations;

7. Policy benefits;

8. Beginning effective date of enrollee coverage;

9. Ending effective date of enrollee coverage (if applicable);10Name of insured policyholder;

11. Social security number of insured policyholder; and

12. Type of insurance coverage (employer, individual, etc.).

ATTACHMENT XII, EXHIBIT G - INDIVIDUAL ENCOUNTER REPORTING/REQUIRED DATA ELEMENTS

ATTACHMENT XII, EXHIBIT G
REQUIRED DATA ELEMENTS FOR REPORTING INDIVIDUAL ENCOUNTERS

This report shall include, at a minimum, the following data elements:

Common Data Elements

Type of Claim
Provider Number Servicing
Provider Number
Primary Care Provider Number (Effective July 1, 1997)
Enrollee Number
Procedure Code
(CPTs and NDCs)
Procedure Modifier
Type of Service
Units
From Date
Through Date
Payment Date
Billed Charges
Allowed Amount
Amount Paid
Primary Diagnosis
Secondary Diagnosis
Diagnosis 3
Diagnosis 4
Diagnosis 5
Provider Type
Provider Specialty
Claim Type Modifier
Third Party Liability Amount

Hospital Specific

Attending Physician
Admitting Physician
Discharge Date
Admit Date
Covered Days
Non-Covered Days
UB-82 revenue Codes
(UB-92 When Implemented)
Revenue Charges
Surgical Procedures (ICD-9)
Per Diem
Bill Type
DRG Data
Admitting Diagnosis
Discharge Diagnosis

Home Health Specific

Attending Physician

Professional Specific

Referring Provider Number
Treatment Place
Anesthesia Units

Community Health Clinic Specific

Drug Codes
Drug Quantity
Drug Day Supply
Drug Charges
Treatment Place
Referring Provider Number

Ambulance Specific

Emergency Date
Referring Provider Number
Destination

Dental Specific

Tooth Number
Tooth Surface
Emergency Indicator

Pharmacy Specific

Prescribing Provider's DEA Number
Prescription Number
Refill Number
Days Supply
Nursing Home Indicator
Unit Dose Indicator

Hospice Specific

Certification Date
Attending Physician
Admitting Physician
Date Care Begins
Treatment Place
Covered Days

ATTACHMENT XII, EXHIBIT H –QUALITY IMPROVEMENT REPORTS

ATTACHMENT XII, EXHIBIT H.1
LEFT BLANK INTENTIONALLY

ATTACHMENT XII, EXHIBIT H.2 – PCP Assignment Reporting

MCO NAME: **REPORTING PARTY:** **TELEPHONE # :**		**REPORTING PERIOD:** **QTR 1 QTR 2 QTR 3 QTR 4** (Please circle)	
QTR	**Numerator: Enrollees not Assigned to a PCP within 30 days of enrollment by Grand Region during the reporting period**	**Denominator: Total number of new enrollees in the Grand Region during the reporting period**	**Rate**
1/1-3/31			**#DIV/0!**
4/1-6/30			**#DIV/0!**
7/1-9/30			**#DIV/0!**
10/1-12/31			**#DIV/0!**

ATTACHMENT XII, EXHIBIT H.3 – Quarterly EPSDT Report

INSTRUCTIONS FOR COMPLETING THE REVISED 2005 EPSDT REPORT

The Bureau of TennCare Division of Quality Oversight has revised the EPSDT reporting format in order to more clearly understand the efforts managed care contractors (MCCs) are making to improve the TennCare EPSDT screening rates. By comparing and contrasting the information provided in the revised reporting format, the Division of Quality Oversight will identify best practices and opportunities for improvement within the processes.

The instructions below provide clarification and examples specific to each section of the report. The requested information for each section is reiterated. The relevant clarifications and examples follow each reporting requirement.

REPORTING REQUIREMENTS:

A. Frequency and Submission of the EPSDT Report:

The completed report must be submitted to TENNCARE by the end of the month following the end of the reporting quarter.

Timeframes Covered by the Reports	Reporting Due Dates
1st Quarter, January 1st through March 31st	**April 30th**
2nd Quarter, April 1st through June 30th	**July 31st**
3rd Quarter, July 1st through September 30th	**October 31st**
4th Quarter, October 1st through December 31st	**January 31st**

The completed electronic format of the report must be submitted via e-mail (INSERT E-MAIL ADDRESS) in addition to a hard copy accompanied by the supporting documentation. An attestation to the accuracy and truthfulness of the report must be signed and dated by the Medical Director and the Chief Executive Officer of the MCC.

The MCC must provide contact information for a single individual who will be responsible for answering questions, or providing clarification, regarding the information submitted. E-mail and telephone contact information for the assigned individual should be listed in the appropriate section of the reporting form.

B. Specific Instructions for Completing the Report by Sections:

Initial Information:

- Give the complete, legal company name
- Fully complete the report contact information
- Check the appropriate box associated with the quarter for which information is being reported.

Section I, EPSDT Outreach Occurring in the Reporting Quarter:

Place an "X" in all applicable boxes within the Table provided.
EXAMPLE:

Specific Outreach	Check Applicable Boxes

Member Handbook	X
Newsletter	X
Reminders Prior to Screening Dues Dates	
Reminders of Overdue Screening Dates	X
Follow-up For Enrollees, eligible for EPSDT, who have not received services within a year	X
Outreach to Pregnant Women advising them of the availability of EPSDT Services for their children	X
Assistance offered to pregnant women in scheduling a timely prenatal Appointment	X
Other EPSDT Related Outreach (List by name and describe below as indicated)	

Provide a brief narrative describing the key elements of each EPSDT outreach to enrollees which has occurred in the reporting quarter, include elements such as:

- Rationale behind outreach, why selected, relevance to the population
- Specific population targeted; i.e., all parents/guardians of children under two years of age
- Focused message; specific information/message communicated to the target population; i.e., screening and immunization schedule for the first two years of life and phone number of the child's assigned primary care provider.
- Components of the outreach; i.e., letter followed by telephone call.

If a specific methodology is in place for contacting members regarding overdue screenings, please provide the specific order of contact attempts, i.e., telephone followed by mailing:

- Supply flow chart if necessary to augment written description

Please provide any metrics associated with the outreach and the frequency of analysis:

- Is the impact of an outreach measured? i.e., comparison annually of EPSDT screening rates for a specific age group, such as < two years of age, pre and post implementation
- Survey to enrollees who went to screenings after receiving an intervention to see if that was why they went

Describe any opportunities for improvement identified and subsequent changes made to the specific outreach programs:

EXAMPLE:

- An opportunity for improvement is identified; i.e., the screening reminders were being mailed one month prior to screening due dates. There was insufficient time for parents/guardians to receive the mailings and make the appointments prior to the screening dues dates.
- Subsequent change made to the outreach program; i.e., the reminders are mailed six weeks prior to the screening due date.

Please provide a sample of the specific outreach materials/mailings/telephone scripts where applicable:

- Newsletters with the applicable article(s) hi-lighted
- Samples of screening reminder card(s)
- Notification forms used for overdue screenings
- Other examples of materials utilized

***(This area will expand to accommodate data entry)*:** Please take the space necessary to accurately describe the outreach. The document will expand to your requirements, rather than limiting you to a preset number of lines within the field.

Section II, EPSDT Eligible Enrollees in Care/Case Management Programs

Please list the specific care/case management programs in which EPSDT eligibles are enrolled:

- Programs may be disease specific such as pediatric asthma, sickle cell disease or diabetes
- Programs may be the case management of enrollees with comorbidities, or those who are seriously and chronically ill

Define the targeted population:

- Please give the specific information which qualifies an enrollee for inclusion in the program such as:
  - a diagnoses of asthma (give current procedural terminology (CPT) codes), with two or more emergency department visits or an inpatient hospitalization within the past twelve months, or
  - a diagnoses of diabetes with an HbA1c of 8 or greater
  - individuals incurring greater than $50,000.00 in medical bills in a twelve month period

Give the length of time each program has been operational:

- Determine the difference in months between the date the program was operational (individuals contacted, enrolled and interventions in place) and the last day of the reporting quarter.

Provide the number of EPSDT eligibles enrolled in each program during the reporting quarter:

- List the number of enrollees in each program who are under twenty-one years of age

Please include the average number of contacts per enrollee, per program:

- Divide the overall number of contacts made specific to each program by the number of enrollees in that program to determine the average number of contacts per enrollee, per program

Provide a brief narrative describing the specific programs listed above: Include the following information:

- Rationale behind each, why implemented, relevance to the population, high-volume or high-risk
- Specific goals of the program; i.e., reduce HbA1c's to 6 or less of the identified diabetic population. Reduce emergency department and inpatient admissions for asthmatics while increasing use of inhaled corticoid steroids and other controller medications. Coordinate the care of individuals with significant comorbidities
- Include the specific components of each program (outreach)
- Include the metrics for each program, the baseline measurement, goals and date of remeasure. The overall metrics of the program will be acceptable. EPSDT specific calculations are not required, if that information is not readily available.

***(This area will expand to accommodate data entry)*:** Please take the space necessary to accurately describe the outreach. The document will expand to your requirements, rather than limiting you to a preset number of lines within the field.

Section III, EPSDT Well Child Screening Information

The total number of EPSDT Well Child Screening encounters received during the reporting quarter:

- Utilize the CPT and ICD-9 codes specific to well child screenings to determine this number **(please see Attachment A)**

The number of overdue EPSDT Well Child Screenings identified during the reporting quarter:

- Individuals that were determined to be eligible who have fallen behind on their screening schedule as of the end of the reporting quarter.

Section IV. Provider Outreach

Is there a mechanism in place to notify primary care providers of EPSDT eligibles who have overdue well child screenings?

- Answer YES or NO, Circle One, the appropriate answer

If the answer is YES, please give a brief description of each outreach, including the frequency of provider contact.

- Describe the method of contact; i.e., facsimile transmission or mailing
- List the frequency of contact; i.e., weekly, monthly or quarterly

List and briefly summarize all EPSDT related provider education which occurred during the reporting quarter. Please provide a sample of the educational materials/information to accompany the report:

- Newsletters with the applicable article(s) hi-lighted
- Notification forms used for overdue screenings, mailings or facsimile transmissions
- Other examples of materials utilized

***(This area will expand to accommodate data entry)*:** Please take the space necessary to accurately describe the outreach. The document will expand to your requirements, rather than limiting you to a preset number of lines within the field.

Section V. Coordination with Other Agencies

Please identify agency and provide a sample of coordination materials/information which occurred during the reporting quarter.

EXAMPLE:

- Head Start; include a sample of materials/information
- WIC; include a sample of materials/information
- Health Department; include a sample of materials/information
- Day Care Licensing; include a sample of materials/information

QUARTERLY EPSDT REPORT

Managed Care Company (MCC):
_____

Report Contact: _____ _____
NAME TITLE

_____ _____
TELEPHONE # E-MAIL ADDRESS

Reporting Quarter (Check Appropriate Box):

1st Quarter of 2005	2nd Quarter of 2005	3rd Quarter of 2005	4th Quarter of 2005
January 1st through March 31st	April 1st through June 30th	July 1st through September 30th	October 1st through December 31st

I. EPSDT Outreach Occurring in the Reporting Quarter:

Place an "X" in the appropriate boxes for enrollee outreach which occurred in the reporting quarter:

Specific Outreach	Check Applicable Boxes
Member Handbook	
Newsletter	
Reminders Prior to Screening Dues Dates	
Reminders of Missed Screening Dates	
Follow-up For Enrollees, eligible for EPSDT, who have not received services within a year	
Outreach to Pregnant Women advising them of the availability of EPSDT Services for their children	
Assistance offered to pregnant women in scheduling a timely prenatal Appointment	
Other EPSDT Related Outreach (List by name and describe below as indicated)	

Provide a brief narrative describing the key elements of each EPSDT outreach to enrollees which has occurred in the reporting quarter. If a specific methodology is in place for contacting members regarding missed screenings, please provide the specific order of contact attempts, i.e., telephone followed by mailing. Please provide any metrics associated with the outreach and the frequency of analysis. Describe any opportunities for improvement identified and subsequent changes made to the specific outreach programs. Please provide a sample of the specific outreach materials/mailings/telephone scripts where applicable. ***(This area will expand to accommodate data entry)*****:**

II. EPSDT Eligible Enrollees in Care/Case Management Programs

Please list the specific care/case management programs in which EPSDT eligibles are enrolled. Define the targeted population and give the length of time each program has been operational. Provide the number of EPSDT eligibles enrolled in each program during the reporting quarter. Please include the average number of contacts per enrollee, per program.

Specific Program	Targeted Population	Date Program was Operational	Number of EPSDT Eligibles Enrolled During the Reporting Quarter	Average Number of Contacts Per EPSDT Enrollee Participating in the Program

Provide a brief narrative describing the specific programs listed above *(This area will expand to accommodate data entry)*:

III. EPSDT Well Child Screening Information

a. **The total number of EPSDT Well Child Screening encounters received during the reporting quarter: _____**

b. **The number of missed EPSDT Well Child Screenings identified during the reporting quarter: _____**

IV. Provider Outreach

a. **Is there a mechanism in place to notify primary care providers of EPSDT eligibles who have missed well child screenings? YES NO**

Circle One

b. **If the answer to "a" is YES, please give a brief description of each outreach, including the frequency of provider contact. Please provide a sample of each outreach to accompany the report *(This area will expand to accommodate data entry)*:**

c. **List and briefly summarize all EPSDT related provider education which occurred during the reporting quarter. Please provide a sample of the educational materials/information to accompany the report *(This area will expand to accommodate data entry)*:**

V. Coordination with Other Agencies

Please identify the specific agency or agencies and provide a sample of the materials/information utilized in the coordination efforts during the reporting quarter *(This area will expand to accommodate data entry)*:

ATTESTATION:

I attest the information contained within this report is true and correct.

_____ _____

Signature, Chief Medical Officer **Date**

_____ _____

Signature, Chief Executive Officer **Date**

ATTACHMENT XII, EXHIBIT I – MONTHLY ACTIVITY REPORT

ATTACHMENT XII, EXHIBIT I
Instructions for Completing the Monthly Activity Report

The following definitions should be used for the purpose of completing the Monthly Activity Report.

- Definitions for reporting Member statistics:

  Abandoned Call: A call in the Member Services telephone line queue that is terminated by the caller before reaching a Member Services Representative.

  Call Abandonment Rate: 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 MCO member services call center as (during member services open hours of operation) during the measurement period. Calls where the member called directly into member services or selected a member services option and was put in the call queue

  Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the measurement period. Calls where the member called directly into member services or selected a member services option and was put in the call queue. Refer to NCQA HEDIS Technical Specifications for further clarification and changes.

  Average Time to Answer: The average time that callers waited in the Member Services telephone queue that were during normal business hours before speaking to a Member Services Representative, report in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

- HEALTH SERVICES CALL REPORTING:

  Abandoned Call: A call in the Health Services Prior Authorization line queue that is terminated by the caller before reaching a Health Services Representative.

  Provider Call Abandonment Rate: 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 CONTRACTOR's health services call center as (during open hours of operation) during the month. Calls where the provider called directly into health services or selected a health services option and was put in the call queue.

  Provider Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's health services call center(s) (during hours of operation) during the quarter. Calls where the provider called directly into health services or selected a health services option and was put in the call queue. Please include detailed rate calculation

  The average wait time spent in queue for providers requesting prior authorization

  Number of provider complaints received, either in writing or by phone during the month.

- CLAIMS PAYMENT TIMELINESS:
  Timeliness of Clean and Unclean Claims Processing: Number of claims processed and, if appropriate, paid within 60 days of receipt divided by the number of all claims processed (for calculation date of receipt counts as day zero)

ATTACHMENT XII, EXHIBIT I

Monthly Activity Report

MCO Name: _____

For the Month Ending: _____

MEMBER SERVICES CALL REPORTING

A. Number of Member Phone Calls Received	Total Number
B. Call Abandonment Rate: 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 CONTRACTOR's member services call center as (during member services open hours of operation) during the month. Calls where the member called directly into member services or selected a member services option and was put in the call queue.	(% of calls abandoned)
C. The average wait time spent in queue for members.	Report in minutes: seconds
D. Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the month. Calls where the member called directly into member services or selected a member services option and was put in the call queue. Please include detailed rate calculation.	(% of calls answered within 30 seconds)

HEALTH SERVICES CALL REPORTING

A. Number of Provider Phone Calls for Prior Authorizations	Total Number
B. Provider Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's health services call center(s) (during hours of operation) during the month. Calls where the provider called directly into health services or selected a health services option and was put in the call queue. Please include detailed rate calculation.	(% of calls answered within 30 seconds)
C. The average wait time spent in queue for providers requesting prior authorization.	Report in minutes: seconds
D. Provider Call Abandonment Rate: 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 CONTRACTOR's health services call center as (during open hours of operation) during the month. Calls where the provider called directly into health services or	(% of calls abandoned)

selected a health services option and was put in the call queue.

E. Number of provider complaints received, either in writing or by phone during the month. Total Complaints

PROVIDER COMPLAINTS

A. Number of Provider Complaints, received in Writing or by Phone

CLAIMS PAYMENT TIMELINESS

A. Percentage of claims processed within sixty (60) days

ATTACHMENT XII, EXHIBIT J – MEDICAL SERVICES MONITORING REPORT

ATTACHMENT XII, EXHIBIT J
Instructions for Completing the Medical Services Monitoring Report

The purpose of this report is to compare payments made to providers by the managed care organization ("MCO") on a date of service incurred basis with the Medical Services Budget Target established by TennCare by Grand Region and in Total. The MCO will submit this report monthly, due by the 21st of the following month. The MCO will 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
P. O. Box 593
Nashville, TN 37202-0593

Email: kgaither@mail.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: jmattingly@mail.state.tn.us

Instructions for completing the report:

- Enter the MCO name.
- Enter the reporting month.
- Enter the monthly number of **TennCare enrollees**.
- Aggregate payments by **Grand Region** based on enrollee 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. For example, if the effective date of the Agreement is July 1, 2001, the Monthly Medical Loss Report for the month of August 2001 shall include all payments made for services incurred after July 1, 2001 through August 31, 2001. Payments made for services incurred prior to July 1, 2001 must be excluded. Thereafter, reporting will be on a calendar year basis.
- Report the amount of **Payments by the Claims Processing System** made for **UB92**, **CMS 1500**, and **dental** claim types in the appropriate supporting triangle lag reports. The amounts entered into the triangle lag reports will automatically be reported in the appropriate incurred month by the Excel spreadsheet. If a subcontractor processes dental 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.
- 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 July 1, 2002 must be excluded.

- 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 updated each month.

- The Excel spreadsheet calculates the **Medical Services Payments and Remaining IBNR for the Month**.

- The Excel spreadsheet calculates the **Medical Loss Ratio** as Total Medical Services Payments and Remaining IBNR divided by the Medical Services Budget Target.

Amendment 7 (cont.)

ATTACHMENT XII, EXHIBIT J.1

Medical Services Monitoring Report

GRAND REGION _____

MCO												
(name)												
Reporting Month	2005											
(enter reporting month)	Incurred Month											
	January	February	March	April	May	June	July	August	September	October	November	December
Enrollment												
Payments for Medical Services for the Month												
UB 92 Payments by the Claims Processing System	0	0	0	0	0	0	0	0	0	0	0	0
HCFA1500 Payments by the Claims Processing System	0	0	0	0	0	0	0	0	0	0	0	0
Dental Payments by the Claims Processing System	0	0	0	0	0	0	0	0	0	0	0	0
Capitation Payments												
Pharmacy Payments												
Subcontractor Payments for Medical Services												
Reinsurance Payment												
Other Payments/Adjustments to Medical Costs												
Less:												
BHO Capitation Revenue												
Pharmacy Rebates												
Recoveries not Claims Payments												
Total Payments for the month	0	0	0	0	0	0	0	0	0	0	0	0
Remaining IBNR for the month												
Payments and Remaining IBNR for the month	0	0	0	0	0	0	0	0	0	0	0	0
Per Member Expense												
Per Member Month Exp. For Quarter												
Per Member Month Exp. For Quarter in 2004												
Per Member Month Exp. For Quarter in 2003												
Percent Change from 2003 to 2004												
Medical Services Budget for 2005 Quarter												
(Over)/Under Budget												

ATTACHMENT XII, EXHIBIT J.2
UB92 Payments by the Claims Processing System

Incurred Month of Service

Month Paid by the Claims System	Total	Before July	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03
Jul-02	0																			
Aug-02	0																			
Sep-02	0																			
Oct-02	0																			
Nov-02	0																			
Dec-02	0																			
Jan-03	0																			
Feb-03	0																			
Mar-03	0																			
Apr-03	0																			
May-03	0																			
Jun-03	0																			
Jul-03	0																			
Aug-03	0																			
Sep-03	0																			
Oct-03	0																			
Nov-03	0																			
Dec-03	0																			
Jan-04	0																			
Feb-04	0																			
Mar-04	0																			
Apr-04	0																			
May-04	0																			
Jun-04	0																			
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

0 **Total for Dates of Service after 7/1/02**

Amendment 7 (cont.)

ATTACHMENT XII, EXHIBIT J.3
HCFA 1500 Payments by the Claims Processing System

Incurred Month of Service

Month Paid by the Claims System	Total	Before July	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	Before July
Jul-02	0																				
Aug-02	0																				
Sep-02	0																				
Oct-02	0																				
Nov-02	0																				
Dec-02	0																				
Jan-03	0																				
Feb-03	0																				
Mar-03	0																				
Apr-03	0																				
May-03	0																				
Jun-03	0																				
Jul-03	0																				
Aug-03	0																				
Sep-03	0																				
Oct-03	0																				
Nov-03	0																				
Dec-03	0																				
Jan-04	0																				
Feb-04	0																				
Mar-04	0																				
Apr-04	0																				
May-04	0																				
Jun-04	0																				
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

0 **Total for Dates of Service after 7/1/02**

Amendment 7 (cont.)

ATTACHMENT XII, EXHIBIT J.4
Dental Payments by the Claims Processing System

Incurred Month of Service

Month Paid by the Claims System	Total	Before July	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03
Jul-02	0																			
Aug-02	0																			
Sep-02	0																			
Oct-02	0																			
Nov-02	0																			
Dec-02	0																			
Jan-03	0																			
Feb-03	0																			
Mar-03	0																			
Apr-03	0																			
May-03	0																			
Jun-03	0																			
Jul-03	0																			
Aug-03	0																			
Sep-03	0																			
Oct-03	0																			
Nov-03	0																			
Dec-03	0																			
Jan-04	0																			
Feb-04	0																			
Mar-04	0																			
Apr-04	0																			
May-04	0																			
Jun-04	0																			
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

0 **Total for Dates of Service after 7/1/02**

ATTACHMENT XII, EXHIBIT K – FQHC REPORTING

ATTACHMENT XII, EXHIBIT K
FQHC REPORTING

MCO Name: _____

As of January 1, _____

Please provide the information identified below for each FQHC in the provider network..

1. FQHC Name: _____
2. FQHC Address: _____
_____

3. Please describe the reimbursement arrangement (check one):

- ❑ Fee-for-service, cost-related basis
- ❑ Capitated basis, considering adverse selection factors

4. If capitated, please explain what adjustments are made for adverse selection and attach a copy of the rates:

5. Covered Services (describe the types of services the FQHC is contracted to provide)

_____

_____

6. Total Amount Paid for the previous twelve (12) month period from July 1 through June 30: _____

ATTACHMENT XII, EXHIBIT L – COST AND UTILIZATION REPORTING

ATTACHMENT XII, Exhibit L.1

[MCO NAME]
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 Adult**	**Uninsured Child**	**Medicall y Eligible Adult**	**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 Pharmacy												
Total Miscellaneous												
Transportation												
Total Capitation												
Vendor A												
Vendor B												
Vendor C												
Vendor D												
Vendor E												

ATTACHMENT XII, Exhibit L.2

[MCO NAME]
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 Adult	Uninsured Child	Medically Eligible Adult	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 XII, Exhibit L.3

[MCO NAME]
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 Adult**	**Uninsured Child**	**Medically Eligible Adult**	**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 Scan Visits per 1,000												
PET Scan Visits per 1,000												
Total Visits per 1,000												
Other Services												

Payment Per Visit												
Payment PMPM												
Visits per 1,000												

ATTACHMENT XII, Exhibit L.4

[MCO NAME]
Cumulative Year to Date
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 Adult	Uninsured Child	Medically Eligible Adult	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												
Gastroenterology												
General Surgery												
Hematology/Oncology												
Neurology												
Orthopedic Surgery												
Pulmonology												
Ophthalmology/Optometry												
Otolaryngology												
Urology												
Emergency Medicine												
Other												
Total Specialist												
Total Primary & Specialty												
Visits Per 1,000												
Total Practitioner												
Radiology												
Anesthesiology												
Pathology												
Total R.A.P.												
Primary Care Adult												
Primary Care Child												

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Primary Care Total												
OB-GYN												
Cardiology												
Gastroenterology												
General Surgery												
Hematology/Oncology												
Neurology												
Orthopedic Surgery												
Pulmonology												
Ophthalmology/Optometry												
Otolaryngology												
Urology												
Emergency Medicine												
Other												
Total Specialist												
Total Primary & Specialty												

ATTACHMENT XII, Exhibit L.5

[MCO NAME]
Cumulative Year to Date
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 Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months												
Member Months												
Total Miscellaneous												
Payment PMPM												
Dental												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												
Durable Medical Equipment												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												
Home Infusion Therapy												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												
Home Health Agency												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												
Orthotics/Prosthetics												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Vision Hardware												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												
Transportation												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												
Other												
Payment PMPM												
Cost Per Unit												
Utilization per 1000												

ATTACHMENT XII, EXHIBIT M – ELIGIBILITY AND PREMIUM RECONCILIATION REPORTING

ATTACHMENT XII, EXHIBIT M.1
ELIGIBILITY AND PREMIUM RECONCILIATION SUMMARY REPORT

<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 tapes received from the State. This row also includes a calculation of the amount of premium expected. The second row (State Info) details the premium actually received from the State, per the monthly premium tape.

Report Definitions

Calculated Age	The age of the member is calculated based on the Start Date, per the premium tape received from the State, less the member's Date of Birth, per the eligibility information maintained by the MCO based on the eligibility tapes received. Neither the member's age nor the Date of Birth are on the premium tape.
MCO Effective Date	The date the MCO has the member effective. The source of this information is the eligibility tape received from the State.
MCO Term Date	The date the MCO has the member termed. The source of this information is the eligibility tape received from the State.
State Start Date	The starting date for which the State is paying premiums, per the premium tape received from the State.
State End Date	The ending date for which the State is paying premiums, per the premium tape received from the State.
Amount Expected	The expected amount of premium to be paid per reporting period, based upon eligibility information.

ATTACHMENT XII, EXHIBIT M.2
ELIGIBILITY AND PREMIUM RECONCILLIATION PREMIUM DESCREPANCY REPORT

<INSERT MCO NAME>
PREMIUM DISCREPANCY REPORT
For the Quarter Ended **<INSERT DATE >**

MCO Info *State Info*	Member Name *Member Name*	ID *ID*	Date of Birth *Date of Birth*	Calc. Age *Calc. Age*	Sex *Sex*	CSA *CSA*	Program Code *Program Code*	Effective Date *Start Date*	Term Date *End Date*	Amount Expected *Received*	Over (Under) Paid
	Smith, John	444-33-1111	08/24/66	34	M	2	87	8/1/01	8/31/01	$ 96.40	
	Smith, John	444-33-1111			M	2	17	8/1/01	8/31/01	14.84	$ (81.56)
	Smith, Jane	444-33-2222	02/13/67	33	F	2	67	7/1/00	12/31/99	714.54	
	Smith, Jane	444-33-2222			F	2	67	7/1/01	8/15/01	357.27	(357.27)
	Jones, Alice	444-33-3333	06/25/57	44	F	4	87	7/1/01	12/31/99	475.41	
	Jones, Alice	444-33-3333			F	4	87	7/1/01	9/30/01	899.10	423.69
	Jones, Steve	444-33-4444	09/30/72	28	M	3	97	8/1/01	12/31/99	508.04	
	Jones, Steve	444-33-4444			M	4	97	8/1/01	9/30/01	501.76	(6.28)
	Robertson, Pat	444-33-5555	11/11/76	22	F	1	67	4/1/99	12/31/99	682.08	
	Robertson, Pat	444-33-5555			M	1	67	7/1/01	9/30/01	283.89	(398.19)

ATTACHMENT XII, EXHIBIT M.3
ELIGIBILITY AND PREMIUM RECONCILLIATION NO PREMIUM REPORT

<INSERT MCO NAME>
NO PREMIUM REPORT
For the Quarter Ended **<INSERT DATE >**

MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Amount Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	*CSA*	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
	Doe, John	555-44-3333	09/29/39	54	M	2	17	1/1/94	12/31/99	$ 44.52	
	-	-			-	-	-	-	-	0.00 $	(44.52)
	Doe, Jane	555-44-4444	01/18/52	49	F	2	67	9/1/01	9/30/01	238.18	
	-	-			-	-	-	-	-	0.00	(238.18)

ATTACHMENT XII, EXHIBIT M.4
ELIGIBILITY AND PREMIUM RECONCILLIATION NO ELIGIBILITY REPORT

<INSERT MCO NAME>
NO ELIGIBILITY REPORT
For the Quarter Ended **<INSERT DATE >**

MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Amount Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	*CSA*	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
-	-	-	-	-	-	-	-	-	$ 0.00		
Jones, John	777-66-5555			M	1	67	7/1/01	7/31/01	94.63	$ 94.63	
-	-	-	-	-	-	-	-	-	0.00		
Jones, Jane	777-66-6666			F	3	97	7/1/01	7/31/01	441.05	441.05	

ATTACHMENT XIII - LEFT BLANK INTENTIONALLY

ATTACHMENT XIV – PREVIOUS CONTRACT REQUIREMENTS

ATTACHMENT XIV

Previous Contract Requirements

Any Managed Care Organization that executed the September 11, 1995 Contractor Risk Agreement, as amended, with the State of Tennessee prior to the effective date of this Agreement is required to satisfy its responsibilities under the previous contract that have not been completed by the execution date of this Agreement. These requirements include, but shall not be limited to, the following provisions: (THIS LIST IS NOT INTENDED TO BE AN ALL INCLUSIVE LIST)

1. **PAYMENT OF THE CAPITATION RATE** (For purposes of this Attachment, sections applying to the financial reporting of accrued receivables by the CONTRACTOR, or the calculation methodology or payment amounts occurring pursuant to Section 2-3.c.1 of the September 11, 1995 Contractor Risk Agreement as amended.

"The CONTRACTOR agrees that by executing this amendment and accepting the capitation rates specified above, the CONTRACTOR automatically and totally waives, releases and discharges any and all claims, whether filed or contemplated, known or unknown against the State of Tennessee (including the Bureau of TennCare, the TennCare Division, all agencies, departments, officials, employees of the State) and the Centers for Medicare and Medicaid Services, related to the financial reporting of accrued receivables by the CONTRACTOR, or the calculation methodology or payment amounts occurring pursuant to Section 2-3.c.1 of the Agreement for services rendered pursuant to the Agreement during the period January 1, 1994 through June 30, 1999. Additionally, the CONTRACTOR agrees that no part of the additional funds that becomes available as a result of this Amendment shall be transferred to an affiliate or management company or otherwise expended for affiliate or management company administrative costs or management fees.

In no event shall this Amendment be interpreted or construed to create any financial obligation of the State except as expressly and clearly provided herein."

2. **PAYMENT OF THE CAPITATION RATE** (for purposes of this Attachment, sections related to executing an expenditure plan for distributing $12.40 per service provider per month at 3-10.b. of the Contractor Risk Agreement dated September 11, 1995 as amended.

The following rates shall be effective for July 1, 1999 through June 30, 2000:

Enrollee Category	Capitation Rate On/after 7/1/99
TennCare Eligibles	
Under Age 1	$ 157.29
Ages 1 to 13	$ 56.80
Ages 14 to 44 (male)	$ 97.07
Ages 14 to 44 (female)	$ 156.54
Ages 45 to 64	$ 164.68
Ages 65 and over	$ 183.66
Aid to the blind and disabled	$ 311.23
TennCare Dual Eligibles	
Medicaid/Medicare Duals	$ 108.25

The CONTRACTOR agrees that the equivalent of $ 12.40 per member per month shall be paid to service providers pursuant to an expenditure plan developed by the CONTRACTOR and approved by TennCare and that the equivalent of $ 3.60 per member per month shall be used at the discretion of the CONTRACTOR for purposes related to compliance with requirements of this Agreement. The capitation

rates in effect on and after July 1, 1999 shall not be paid until such time as the CONTRACTOR has submitted and TennCare has approved an expenditure plan. Thereafter, failure of the CONTRACTOR to adhere to the plan approved by the State will result in the assessment of liquidated damages as specified in Section 4-8 of this Agreement.

ATTACHMENT XV - RISK BANDING MANUAL

ATTACHMENT XV

Profit/Loss Risk Banding

MCO Manual

State of Tennessee
Bureau of TennCare

Revised May 7, 2001

Table of Contents

Section One **Description of Risk Banding Program**
Section Two **Risk Banding Options**
Section Three **Adjudication/Reconciliation Methodology**
Section Four **Risk Banding Definitions**
Section Five **Contract Terms**

Section One
Description of Risk Banding

The purpose of this program is to allow a Managed Care Organization (MCO) to limit their net profit or loss based upon their participation in the TennCare program.

TENNCARE will pay a capitation rate using a capitation rate schedule. In addition, the Bureau will allow the MCOs the option of participating in a profit/loss risk banding program. The profit/loss risk banding is intended to share risk between the State and the MCOs at predetermined coinsurance levels that vary by the level of profit and loss actually incurred and reported to the Tennessee Department of Commerce and Insurance (TDCI). For those MCOs who choose to not participate, they are at risk for 100% of the profit and loss surrounding the capitation payments. If the Contractor elects Option 1 or Option 2, the risk band will be effective for July 1, 2001 through December 31, 2001. The MCO may opt to change risk band options a final time by notifying the State in writing no later than December 1, 2001, and the subsequent risk band option will be effective January 1, 2002 through December 31, 2003. If the Contractor elects Option 3, the risk band will be effective for July 1, 2001 through June 30, 2002. At the end of this period, the Contractor shall select an alternative risk band option that shall be effective January 1, 2003 through December 31, 2003 and provide notice of said selection in writing, no later than June 30, 2002.

All TennCare eligible populations are covered by the risk banding, as well as all medically necessary TennCare covered services as described in the contractor risk agreement (CRA) and any subsequent amendments.

Section Two
Risk Banding Options

Each MCO has the option of electing to participate in the State-sponsored Profit/Loss Risk Banding program. Each MCO must choose one of the following three options:

Option 1

Under Option 1, risk sharing varies dependent upon the percentage above and below total TennCare revenue. Profits and losses are calculated as a percentage of total TennCare Revenue. For losses between 0 to 10% of TennCare revenue, TENNCARE will pay for 50% of the Contractor's net loss. For profits between 0 to 10% of TennCare revenue the Contractor will pay TennCare 70% of its net income. The amount of risk-sharing when risk is 10% above or below TennCare revenue varies by year. The chart below displays TENNCARE's share of risk.

Risk Band Period	*Net Income between 0-10%*	*Net Loss between 0-10%*	*Net Income greater than 10%*	*Net Loss Greater than 10%*
Year ending 12/31/01	**70%**	**50%**	**90%**	**90%**
Year ending 12/31/02	**70%**	**50%**	**80%**	**80%**
Year ending 12/31/03	**70%**	**50%**	**70%**	**70%**

Net Income/Net Loss Calculation

TENNCARE will calculate a CONTRACTOR's net income/net loss under Option 1 by subtracting covered services, premium tax and administrative expenses from an MCO's total TennCare revenue. TennCare revenue includes any additional income generated by investment income as a result of the deposit of the capitation payment from TENNCARE into an interest bearing account. If investment income attributable to the deposit of capitation payments from TENNCARE in an interest bearing account is not tracked due to the manner in which financial deposits are maintained, the CONTRACTOR must submit an allocation methodology for the determination of investment income to TENNCARE for approval prior to submission of the settlement calculation. All calculations on expenses must include any third party liability recoveries as a negative expense and include the net impact of any reinsurance program and pharmacy rebates. If this calculation results in income (revenue exceeds expenses), all expenditures below the 100% of the total TennCare revenue, net of premium tax, will be shared according to the tables above.

If the calculation results in a loss (expenses exceed revenues), all expenditures above 100% of total TennCare revenue, net of the premium tax, will be shared according to the tables above.

Option 2

Under this option, risk-sharing varies dependent upon the percentage above the minimum medical loss ratio. The CONTRACTOR is responsible for the first 2% of medical costs, regardless of profit or loss, beyond the minimum 85% Medical Loss Ratio (MLR). The State will pay for 50% of additional medical costs between an 87% to 97% MLR. Above a 97% MLR the State will pay the following percentage of medical costs:

July 1, 2001 – December 31, 2001 90%
January 1, 2002 – June 30, 2002 80%
January 1, 2003 – December 31, 2003 70%

Excluding the premium tax, an administrative fee of 11% of the capitation payment will be established with two (2) percentage points dependent on the achievement of benchmark levels of performance for specific performance indicators. Any CONTRACTOR electing to participate in this risk-sharing option agrees to participate in a workgroup facilitated by the TennCare Chief Medical Officer to finalize benchmarks and the methodology for calculating the performance indicators specified below. With the exception of EPSDT, HEDIS Medicaid technical specifications shall be followed for the calculation of clinical performance indicators. Two (2) percentage points of the administrative fee will be allocated over the ten (10) performance indicators specified below. New or additional performance indicators may be added at the mutual agreement of TENNCARE and the CONTRACTOR. The CONTRACTOR must obtain the benchmark performance level for each indicator specified to be eligible for the portion of the two (2) percentage points allocated to that performance indicator. TENNCARE may modify the benchmarks on an annual basis to facilitate continuous improvement. The workgroup established above will participate in the specification of new benchmarks.

The administrative performance indicators and benchmarks are:

Performance Indicator	Data Sources	Measure	Target	Benchmark
Administrative Services				
Claims Payment Accuracy (10%)	Monthly statistically significant sample[2]	# of Claims paid accurately upon initial submission	100 percent	97 percent accuracy upon initial submission
Abandonment rate for Member Services lines (10%)	Weekly MCO	Percent of calls not answered; callers hang up while in queue	0 percent	Less than 5 percent of calls not answered

[2] If the sample used to calculate the performance indicator is based on the CONTRACTOR's total book of business, TENNCARE reserves the right to require the CONTRACTOR to validate the accuracy based on a sample of TennCare claims or phone calls only at any time.

Performance Indicator	Data Sources	Measure	Target	Benchmark
Administrative Services				
Specialist Provider Network (10%)	Monthly Provider listing	Executed Contract Agreements	Same as benchmark	Executed specialty physician contracts in all priority areas designated by the state located within the MCO's Grand Region for the following nine (9) specialists: cardiology, gastroenterology, neurology, neurosurgery, otolaryngology; ophthalmology, orthopedics, oncology/hematology and urology

With the exception of EPSDT, benchmarks will be finalized after analysis of current MCO performance levels. The benchmark for EPSDT shall be an adjusted periodic screening percentage of greater than 80%.

Performance Objective	Data Sources	Measure	Target	Benchmark
Clinical Quality				
Childhood Immunizations (10%)	MCO encounter data; TennCare enrollment data	percent of two-year old children receive all 12 recommended vaccines	100% of children immunized	**To be determined**.
Adolescent Immunizations (10%)	MCO encounter data ;TennCare Enrollment data	percent of enrolled adolescents (who turn 13 during measurement year) receive recommended vaccines	100% of adolescents immunized	**To be determined**.
Checkups After Delivery (10%)	MCO encounter data ;TennCare enrollment data	percent of female enrollees receive a post partum checkup 3-8 weeks after delivery	100% of women that delivery receive a check-up	**To be determined**.
Cervical Cancer Screening	MCO encounter data;	percent of enrolled women (ages 21-64) receive one or	According to ACOG guidelines	**To be determined**.

	data	or the two years prior to the reporting year		

Performance Objective	Data Sources	Measure	Target	Benchmark
Breast Cancer Screening (7.5%)	MCO encounter data; TennCare enrollment data	percent of enrolled women who received a mammogram in the past two years	According to ACOG guidelines	**To be determined**.
HBA1c Testing (5%)	MCO encounter data; TennCare enrollment data	percent of members age 18 through 75 with one or more tests conducted during the measurement year. Notation in the medical record of any one of the following is acceptable: Glycated hemoglobin Glycosylated hemoglobin A1c Glyco hemoglobin A1c HBA1c hemoglobin A1c	At least one test each year	**To be determined.**
EPSDT (20%)	MCO encounter data; TennCare enrollment data	The percentage of children who received a periodic screen including all components (consistent with EPSDT Consent Decree Definition)	100% screening	Adjusted screening rate greater than 80%

EPSDT Phase-In

An emphasis has intentionally been placed on improving the EPSDT screening rate by way of allocating 20% of the incentive fund to this performance indicator. In order to facilitate the movement of plans toward this benchmark, incentive payments shall be structured to account for improvements over the MCO's baseline position. MCOs that exceed the 80% benchmark shall receive 100% of the funds allocated to this indicator. Any MCO that improves their adjusted periodic screening rate by at least 10 percentage points, shall be paid a percentage of the incentive fund allocated to this performance indicator equivalent to the percentage increase over the baseline that has been obtained.

Medical Expense Reconciliation

To determine the settlement amount, TENNCARE will calculate the percentage of capitation payment received from TENNCARE that was paid for covered medical expenses net of pharmacy rebates, net of third party liability recoveries or subrogation activities, and net of the impact of reinsurance for the settlement period (the medical loss ratio). Subcontractor expenses shall not be included as a medical expense for the purpose of this calculation if the subcontractor was engaged to perform administrative functions only (e.g., claims processing). If this calculation results in a medical loss ratio of 87% or lower, all covered medial expenses will be the responsibility of the CONTRACTOR. If this calculation results in a medical loss ratio between 87% and 97%, TENNCARE will pay for 50% of covered medical expenses between an 87% to 97% MLR. If this calculation results in a medical loss ratio greater than 97%, TENNCARE will pay for 50% of covered medical expenses between an 87% to 97% MLR and share the amount of covered medical expenses above 97% according to the schedule described above. For the purpose of Option 2, investment income is considered the property of the CONTRACTOR and will not be included in the calculation of the settlement amount described in this paragraph.

Administrative Costs

Excluding the premium tax, an administrative fee of 11% of the capitation payment will be established with two (2) percentage points dependent on the achievement of benchmark levels of performance for specific performance indicators. TENNCARE will retain two (2) percentage points of the administrative fee until receipt of the CONTRACTOR's performance objective report. Performance objective results shall be submitted to the State within ninety (90) days of the ending of the six month and yearly settlement periods, unless an alternative reporting timeframe is agreed upon by the Performance Objective workgroup.

The CONTRACTOR is fully responsible for all administrative costs. In the event that the CONTRACTOR's actual administrative costs as defined in Section 1-3 Item 1 and Item 49.e.4 are greater than or less than the portion of the capitation payment allocated to administrative costs in Option 2, neither the resulting profit or loss shall be considered in the medical expense reconciliation.

Audit

The CONTRACTOR will not be automatically subject to an audit of administrative costs in the event that the State shares in losses. The preceding statement does not waive TENNCARE's right to audit the CONTRACTOR as specified in the Contractor Risk Agreement.

An MCO in which a provider or a provider entity has an indirect ownership interest, an ownership interest or a control interest as described in Title 42, Part 455, Subpart B of the Code of Federal Regulations shall be subject to a separate audit requirement. Option 2 shall only be available to a Managed Care Organization in which a provider or a provider entity has an indirect ownership interest, an ownership interest, or a control interest as defined at Title 42, Part 455, Subpart B of the Code of Federal Regulations, if the MCO agrees to allow TENNCARE to audit the CONTRACTOR's reimbursement methodology and utilization management criteria, first, prior to the effective date of this Option, and again, after receipt of the settlement calculation for each settlement period. The purpose of the audit is to determine whether the CONTRACTOR pays more for similar services rendered by a related provider or subcontractor or applies differing utilization management controls than the CONTRACTOR pays or applies to providers and subcontractors that do not have an indirect ownership or control interest in the MCO, an MCO's affiliate or an MCO's management company for similar services. If TENNCARE determines the CONTRACTOR pays related providers more than other providers or applies significantly different utilization management criteria during the initial audit, the CONTRACTOR shall not be permitted to elect Option 2. If TENNCARE determines the CONTRACTOR pays related providers more than other providers at a subsequent audit, the provisions specified in Section 3-10.e.3 shall apply.

Option 3

The CONTRACTOR is responsible for the first $33 million in losses incurred during the period July 1, 2001 through June 30, 2002. Prior to July 1, 2001, any Contractor selecting this option shall establish two separate accounts funded with $28 million dollars for operations expenses ("the Operations Account") and $5 million dollars for legal expenses and defense costs ("the Legal Contingency Account"). The CONTRACTOR shall allocate TennCare Contractor Costs defined as premium tax plus medical expenditures for covered services to the Operations Account. The CONTRACTOR shall allocate all non-medical liability costs to the Legal Contingency Account. Non-medical liability costs shall include, but not be limited to, legal defense costs, fees and damages associated with the Contractor's participation in the TennCare Program. In addition, said non-medical liability costs shall include costs for indemnification for such costs to the directors, officers, employees, agents and representatives of the CONTRACTOR and/or its parent company which are associated with the participation of those companies in the TennCare Program.

Account Operation

From July 1, 2001 through June 30, 2002, the CONTRACTOR shall deposit the capitation payments received from TENNCARE to the Operations Account to pay its Administrative Fee, in the amount specified below, and Contractor Costs related to its participation in the TennCare program. The Operations Account shall not be increased by the amount of investment income that the CONTRACTOR receives on the Operations Account nor by the Administrative Fee paid to the CONTRACTOR as specified below.

In the event that the CONTRACTOR's TennCare Contractor Costs allocated to the Operations Account exceed the $28 million in CONTRACTOR funds deposited in the Operations Account and the total of the difference between capitation payments received from TENNCARE and the fixed Admin Fee specified below, the State shall reimburse the CONTRACTOR for TennCare Contractor Costs exceeding the $28 million dollars at risk in the Operations Account, in accordance with the reimbursement methodology set forth in Section 4-26(2) of the CRA, provided, however that the Administrative Fee paid shall be equal to the amount described below for the applicable time period. The State is not responsible for and will not reimburse the CONTRACTOR for any non-medical liability costs. The CONTRACTOR is obligated and responsible for all of its non-medical liability costs, including any liability exceeding the $5 million deposited in the Legal Contingency Account for that purpose.

At the end of the term from July 1, 2001 through June 30, 2002:

(iii) In the event that any balances remain in the Operations Account and the Legal Contingency Account, those accounts shall be reconciled and all funds remaining shall be the sole property of the CONTRACTOR;

(iv) In the event that any balance remains in the Legal Contingency Account and no balance remains in the Operations Account, the balance of the Legal Contingency Account will be applied to the amount of the funds the State has reimbursed the CONTRACTOR for TennCare Contractor Costs exceeding the $28 million dollars at risk in the Operations Account and said balance shall become the sole property of the State.

If the MCO's contract term ends December 31, 2003, the CONTRACTOR shall select an alternative profit/loss risk banding option that shall be effective January 1, 2003 through December 31, 2003 and provide notice of said selection, or notice of non-renewal consistent with Section 4-2.f of the CRA, in writing, no later than June 30, 2002.

Administrative Fee

Excluding the premium tax, an Administrative Fee will be established equivalent to 8.20% of the CONTRACTOR's average capitation payment for the month of January 2001 for the Contractor's intended service area. The product of this calculation stated on a per member per month basis will then be multiplied by 1.04 (to adjust for inflation) to calculate the Administrative Fee to be paid effective July 1, 2001. If the CONTRACTOR was not a TennCare MCO as of January 2001, the Administrative Fee will be equivalent to 8.20% of the average capitation payment for enrollees in the new MCO's authorized service area. The product of this calculation stated on a per member per month basis will then be multiplied by 1.04 (to adjust for inflation) to calculate the Administrative Fee to be paid effective July 1, 2001. The Administrative Fee shall serve as payment for all administrative costs, defined as all non-medical costs including costs of subcontractors engaged to perform an administrative function specifically related to securing or fulfilling the CONTRACTOR'S obligations to TENNCARE under the terms of the CRA and costs associated with liquidated damages.

The administrative fee may be increased up to 4% effective as of July 1, 2002 and will be payable as herein after described. However, up to two points of the administrative fee inflation factor will be forfeited in the event the CONTRACTOR fails to achieve benchmark levels of performance for specific performance indicators. New or additional performance indicators may be added at the mutual agreement of TENNCARE and the CONTRACTOR. The CONTRACTOR must obtain the benchmark performance level for each indicator specified to be eligible for the portion of the inflation adjustment factor allocated to that performance indicator. TENNCARE may modify the benchmarks on an annual basis to facilitate continuous improvement.

The administrative fee inflation factor will be applied after receipt of the CONTRACTOR's performance indicator report. Performance indicator results shall be submitted to the State within ninety (90) days of the twelve (12) month period ending June 30th, unless an alternative reporting timeframe is agreed upon. The State shall calculate the inflation adjustment factor within thirty (30) days or receipt of the performance objective report. The inflation adjustment factor shall be applied retroactively to July 1, 2002. The administrative performance indicators and benchmarks are:

Performance Indicator	Data Sources	Measure	Target	Benchmark
Administrative Services				
Claims Payment Accuracy	Weekly Activity Report	# of Claims paid accurately upon initial submission	100 percent	97 percent accuracy upon initial submission
Approximate Waiting Time for Provider Response	Weekly Activity Report	Average response time on Provider Services Line	Average response time of 30 seconds, industry standard	Average response time of 60 seconds
Abandonment Rate for Member Services Line	Weekly MCO report – revised	Percent of calls not answered; callers hang up while in queue	0 percent	Less than 5 percent of calls not answered
Approximate Waiting Time for Member Response	Weekly Activity Report	Average response time on Member Services Line	Average response time of 30 seconds, industry standard	Average response time of 60 seconds
Specialist Provider Network	Monthly Provider listing	Executed Contract Agreements	Same as benchmark	Executed specialty physician contracts in all priority areas designated by the state located within the MCO's Grand Region for the following nine (9) specialists: cardiology, gastroenterology, neurology, neurosurgery, otolaryngology; ophthalmology, orthopedics, oncology/hematology and urology

Section Three
Adjudication/Reconciliation Methodology

Adjudication

MCO's must submit their preliminary payout estimates for their net income or loss within ninety (90) days of the end of the settlement period. Any payouts made by the Bureau or the MCO must include the final impact on MCO net income or loss as a result of the 85% medical loss reconciliation process. The State must make a preliminary payout within sixty (60) days of the receipt of the MCOs preliminary estimate and only after the final 85% medical loss ratio reconciliation has been completed. The final payout will be based on final claims run-out for the period ending either December 31 or June 30. The final claims run-out must include an incurred but not reported amount certified by an actuary that demonstrates a claim run-out of 95% for the settlement period has been achieved and the medical loss ratio reconciliation (required to be completed within ninety (90) days of the end of the settlement period) has been accomplished.

Any error of estimation as a result of the final adjudication of the profit/loss risk banding or the medical loss ratio reconciliation will be included in the next settlement period's calculations.

MCOs must agree to reasonable reimbursement standards to be determined in conjunction with the actuarially sound rate setting assumptions. The CONTRACTOR shall not pay more for services rendered by any provider or subContractor that is related to the CONTRACTOR than the CONTRACTOR pays to unrelated providers and subContractors for similar services. Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be reduced from total expenditures prior to the State sharing in any losses. Likewise, this excess payment will be excluded in the calculation of the medical loss ratio requirement. All reimbursement paid to providers is subject to audit by the State.

On an annual basis, the MCOs are required to spend 85% of their total capitation payments received from TENNCARE upon payments to providers for covered medical services. This 85% standard, known as the 85% Medical Loss Ratio (MLR) standard, will be reconciled for each settlement period for MCOs participating in the optional profit/loss risk-banding program. The Bureau will be monitoring the MCOs' progress towards the 85% standard monthly, with the Bureau reporting the progress to the Funding Board. The Bureau may require the MCO to submit a corrective action plan to demonstrate how it will meet the 85% on an annual basis. Any corrective action plan or reconciliation payments must be factored into the profit/loss calculations for the purpose of this profit/loss risk banding agreement. If the CONTRACTOR elects to change risk-band options, or change from assuming full risk to risk-sharing, the CONTRACTOR must demonstrate it has satisfied the MLR requirement for the period prior to the effective date of the risk band option before completing a calculation showing profit and loss for the purpose of determining risk-sharing amounts.

Administrative costs will be audited for reasonableness under Option 1 only when the State is sharing in a loss.

The Bureau will be responsible for overseeing the administration of the risk banding methodology and will be responsible for clearly defining appropriate expenses to be included within each of the three categories:

- Medical Expense
- Administrative Expense
- Profit/Risk/Contingency

Section Four

Risk Banding Definitions

Administrative Costs

Costs that are non-medical in nature. In the event that the State shares in an MCOs losses, under profit/loss risk-banding Option 1, administrative costs will be audited for reasonableness in accordance with standards established by the Comptroller of the Treasury. Premium tax is considered to be an Administrative Cost. Cost of subcontractors engaged to perform and 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, marketing) are considered to be an administrative cost.

Medical Expenses (Covered Medical Services)

1. The cost of providing TennCare Program medical services to enrollees as identified and pursuant to the following listed subsection of Section 2-3 of the CRA:
   a. 2-3.a. Covered Services
   b. 2-3.c. Specialized Services
   c. 2-3.h. Use of Cost Effective Alternative Services
   d. 2-3.j. Primary Care Providers/Case Management/Continuity of Care/Disease Management
   e. 2-3.o coverage of Sterilizations, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
   f. 2-3.p. Coverage of Organ Transplants
   g. All services related to hospice
   h. Capitated payment to licensed health care providers
   i. Medical care services directed by TENNCARE or an administrative law judge
   j. Net impact of reinsurance coverage purchased by the MCO
2. Preventive Service: In order for preventive services in Section 2-3 (including, but not limited to, health education and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR'S enrollees or targeted to meet the enrollee's individual needs.
3. For the purposes of determining Medical Loss Ratio, Medical Expenses do not include:
   a. 2-3.g. Services Not Covered
   b. 2.3.h. Institutional Services and Alternative to Institutional Services
   c. Services eligible for reimbursement by Medicare
   d. The activities described in or required to be conducted in Attachments II, III, IV, V, VI, VII, IX & X (including, but not limited to, utilization management, utilization review activities) are administrative costs.
4. Medical expense will be net of any third party liability recoveries or subrogation activities.
5. Medical expense will be net of any pharmacy rebates.
6. This definition does not apply to NAIC filings.

Medical Loss Ratio
The percentage of capitation payment received from TENNCARE that is paid for covered medical expenses net of third party liability recoveries and reinsurance premiums and recoveries.

NAIC

National Association of Insurance Commissioners

Net Income
Using the calculations described within the profit/loss Risk Banding Manual, when total TennCare revenues exceed total expenses, adjusting for the actual results of the actuarially certified claims runout.

Net Loss
Using the calculations described within the profit/loss Risk Banding Manual, when total expenses exceed total revenues, adjusting for the actual results of the actuarially certified claims runout.

TennCare Revenues
TennCare revenues includes capitation premium revenues paid by the State of Tennessee (State) to the contracted TennCare MCOs. For the purpose of risk-banding Option 1 TennCare Revenues also include investment income derived solely from a deposit of a capitation payment in an interest bearing account.

Section Five
Contract Terms

The MCO may change the risk band option by notifying the State within seven (7) days of receipt of the recalibrated rates after the open enrollment period in 2001. If the Contractor elects Option 1 or Option 2, the subsequent risk band will be effective from July 1, 2001 through December 31, 2001. The MCO may opt to change risk band options a final time by notifying the State in writing no later than December 1, 2001, and the subsequent risk band option will be effective January 1, 2002 through December 31, 2003. If the Contractor elects Option 3, the risk band will be effective from July 1, 2001 through June 30, 2002. At the end of this period, the Contractor shall select an alternative risk band option that shall be effective January 1, 2003 through December 31, 2003 and provide notice of said selection in writing, no later than June 30, 2002.

TENNCARE reserves the right to modify the availability of the optional profit/loss risk-banding program prior to the beginning of each calendar year with the mutual agreement of the CONTRACTOR. MCOs who choose not to participate in the optional profit/loss risk banding program are at risk for 100% of any profit or loss resulting from participation in the TennCare program for the entire Contract period ending December 31, 2003.

The risk band options shall be calculated based upon services rendered to enrollees and expenses incurred by the Contractor and the revenues received by the contractor for the applicable calculation period. The risk band option 1 and 2 will be calculated for the settlement periods of July 1 through December 31, 2001, and thereafter for calendar year periods. Risk band Option 3 will be calculated for the settlement period July 1, 2001 through June 30, 2002.